NOVITAS SOLUTIONS - Part B
RETURN OF MONIES TO MEDICARE

Date form is being completed:

MAIL TO: Novitas Solutions - CASHIER. Please select the address according to the state you rendered services:
AR - PO Box 3091, Mechanicsburg, PA 17055-1809 **CO/NM/OK** - PO Box 3105, Mechanicsburg, PA 17055-1821 **DCMA/DE** - PO Box 3405, Mechanicsburg, PA 17055-1848 **LA** - PO Box 3090, Mechanicsburg, PA 17055-1808 **MD** - PO Box 3404, Mechanicsburg, PA 17055-1847 **MS** - PO Box 3128, Mechanicsburg, PA 17055-1833 **NJ** - PO Box 3034, Mechanicsburg, PA 17055-1805 **PA** - PO Box 3304, Mechanicsburg, PA 17055-1838 **TX** - PO Box 3106, Mechanicsburg, PA 17055-1822

Please select one provider: ☐ AR ☐ CO ☐ DCMA ☐ DE ☐ LA ☐ MD ☐ MS ☐ NJ ☐ NM ☐ OK ☐ PA ☐ TX

This form, or a similar document containing the following information , should be completed fully and accompany each unsolicited/voluntary refund check so that your refund can be properly recorded and applied. In addition:

- **Multiple Claims being refunded:** If refunding multiple claims, list all claim numbers and the required data on a separate sheet if necessary.
- **Medicare Secondary Payment (MSP) Refunds:** Include a copy of the primary insurer's explanation of benefit (EOB) & indicate the MSP reason (see below).
- **Statistical Sampling:** If specific Beneficiary/HIC/Claims data is not available, indicate the methodology and formula used to determine the refund amount and explain the reason for the refund.
- **OIG Self Disclosure:** Providers/Physicians/Suppliers and other entities submitting a refund under the OIG's Self Disclosure Protocols are not provided appeals rights as stated in the signed agreement presented by the OIG.
- **OIG Reporting Requirements:** Do you have a Corporate Integrity Agreement (CIA) with the OIG? ☐ Yes ☐ No
  Are you participating in the OIG Self-Disclosure Protocol? ☐ Yes ☐ No

For each claim the required fields to be completed are noted with *. If the required fields for specific Patient/HIC & Claim Numbers are not completed, NO appeal rights can be provided for this voluntary refund.

BILLING PROVIDER / PHYSICIAN / SUPPLIER NUMBER	*BENEFICIARY MEDICARE HEALTH INSURANCE NUMBER / HIC
NPI NUMBER	*BENEFICIARY NAME (Patient)
PROVIDER / PHYSICIAN / SUPPLIER NAME	BENEFICIARY ADDRESS
PROVIDER / PHYSICIAN / SUPPLIER ADDRESS (Street, City, State, Zip Code)	PROVIDER / PHYSICIAN / SUPPLIER REFUND CHECK NUMBER
PROVIDER OFFICE CONTACT TELEPHONE NUMBER	PROVIDER / PHYSICIAN / SUPPLIER REFUND CHECK DATE
BILLING OFFICE CONTACT NAME & TELEPHONE NUMBER	PROVIDER / PHYSICIAN / SUPPLIER TAX ID NUMBER

*CLAIM NUMBER/ICN	CLAIM BILLED AMOUNT	DATES OF SERVICE(s)	CLAIM AMOUNT BEING RETURNED (check amount)

***REASON CODES FOR EACH CLAIM INCORRECT PAYMENT (Required to check one reason code per refunded claim):**

***Billing/Clerical**

- ☐ 01-Corrected Date of Service
- ☐ 02-Duplicate - **Indicate BothClaim Number/ICN's**
- ☐ 03-Corrected CPT Code
- ☐ 04-Not Our Patient
- ☐ 05-Mod. Add/Remove
- ☐ 06-Billed in Error

***MSP/Other Payer Involvement**

- ☐ 07-MSP Group Health Plan Insurance
- ☐ 08-MSP No Fault Insurance, Date of Incident: _____
- ☐ 09-MSP Liability Insurance, Date of Incident: _____
- ☐ 10-MSP, Workers Comp, Date of Incident: _____
- ☐ 11-Veterans Administration

***Miscellaneous**

- ☐ 12-Insufficient Doc
- ☐ 13-Patient Enroll HMO
- ☐ 14-Svcs Not Rendered
- ☐ 15-Medical Necessity
- ☐ 16-Other-Please Specify: _____

OTHER INSURER INFORMATION (MSP):

Name: _____
Address: _____
City/State/Zip: _____
Telephone # (if available): _____

EMPLOYER INFORMATION (MSP):

Name: _____
Address: _____
City/State/Zip: _____
Telephone # (if available): _____
Subscriber/Member/Policy #: _____

Please return this completed form with your remittance.

Medicare Part B