



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



### Voluntary Refund Overpayment — Check Enclosed

ALL fields are **REQUIRED**.

For your convenience, submit this form and your payment electronically via the eServices portal located at [www.PalmettoGBA.com/eServices](http://www.PalmettoGBA.com/eServices) or complete this form and mail to the address at the bottom of this form.

Please indicate where the services were provided

North Carolina      South Carolina      Virginia      West Virginia

Provider Information	Patient & Claim Information	Enclosed Check Information
Provider Name: <input type="text"/>	Patient Name: <input type="text"/>	Enclosed Check Number: <input type="text"/>
Provider Address: <input type="text"/>	Medicare Beneficiary Identifier (MBI): <input type="text"/>	Enclosed Check Amount: <input type="text"/>
Contact Name: <input type="text"/>	Claim Number (DCN): <input type="text"/>	Enclosed Check Date: <input type="text"/> / <input type="text"/> / <input type="text"/>
Contact Direct Telephone & Extension ( <input type="text"/> ) <input type="text"/> - <input type="text"/> x <input type="text"/>	Claim Date(s) of Service: <input type="text"/>	Overpaid Amount: <input type="text"/>
National Provider Identifier (NPI): <input type="text"/>	CPT Code(s): <input type="text"/>	
Provider Number (PTAN): <input type="text"/>	Diagnosis Code(s): <input type="text"/>	
Tax ID: <input type="text"/>		

Yes, we have a corporate Integrity Agreement with OIG

#### Reason(s) for Overpayment (Please select from the list below)

Billed in Error	Service Not Rendered
Incorrect Service Date (Please provide correct date of service): / /	Modifier Added or Removed (Please provide correction you wish to make):
Duplicate Payment (Please provide correct payment date): / /	Medical Necessity Not Met (Please explain. Attach additional sheet if necessary):
Incorrect CPT Code (Please provide correct CPT code):	Patient Enrolled in HMO (Please indicate which HMO):
Not Our Patient(s) (Please explain circumstance):	Other (Please explain):

(Please list all claim numbers involved. Attach separate sheet, if necessary.)

**Note:** If specific patient/MBI/claim amount data is not available for all claims due to statistical sampling, please indicate methodology and formula used to determine amount and reason for overpayment.

**Note:** If specific patient/MBI/claim # information is not provided, no appeal rights can be afforded with respect to this refund.

**PLEASE ATTACH:**

- Please complete this form and include it with your submission.
- Please attached detailed information. For overpayments that involve multiple patients, please submit detailed information for each.
- Please enclose the check made payable to Palmetto GBA or Medicare, otherwise the check cannot be accepted for deposit.

Please send this form and all additional documentation to

Palmetto GBA, LLC  
Finance & Accounting  
P.O. Box 100246  
Columbia, SC 29202

FN-JM-B-2020

