



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



### Medicare Secondary Payer 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

North Carolina Provider Information	South Carolina Patient & Claim Information	Virginia Other Insurance Information
Provider Name: <input type="text"/>	Patient Name: <input type="text"/>	Insurance Name (if applicable): <input type="text"/>
Provider Address: <input type="text"/>	Medicare Beneficiary Identifier (MBI): <input type="text"/>	Insurance Address: <input type="text"/>
Provider Telephone Number: ( <input type="text"/> ) <input type="text"/> - <input type="text"/>	Claim Number (DCN): <input type="text"/>	Insured Name (if applicable): <input type="text"/>
Contact Name: <input type="text"/>	Claim Date(s) of Service: <input type="text"/>	Insured ID Number (if applicable): <input type="text"/>
National Provider Identifier (NPI): <input type="text"/>	CPT Code(s): <input type="text"/>	Primary Payer Allowance: <input type="text"/>
Provider Number (PTAN): <input type="text"/>	Diagnosis Code(s): <input type="text"/>	Primary Payer Payment: <input type="text"/>
Tax ID: <input type="text"/>	Overpaid Amount: <input type="text"/>	

Yes, we have a Corporate Integrity Agreement with OIG

#### Check Information

Check Number:       Check Date:  /  /

Check Amount:

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

Group Health Plan Insurance	Workers' Compensation	End Stage Renal Disease (ESRD)
No Fault Insurance	Black Lung	Disability
Liability Insurance	Other Insurance Involvement ( <b>Please Explain in the Space Below</b> ):	

**PLEASE ATTACH:**

- Please complete this form and include it with your submission.
- Please attach 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.
- If the primary insurance payer has not been determined, please make the check out for the entire amount of the claim.
- Please include a copy of explanation of benefits received from other insurance.

MS-HHH-A-2510



Revised 12/2019

Please send this form and all additional documentation to  
Palmetto GBA/Medicare  
Medicare HHH - Finance & Accounting  
P.O. Box 100277  
Columbia, SC 29202-3277