



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



Medicare Secondary Payer Inquiry Form

ALL fields are REQUIRED.

For your convenience, please complete this form and mail to the address at the bottom.

Provider Information

Patient & Claim Information

Other Insurance Information

Provider Name:

Patient Name:

Insurance Name (if applicable):

Provider Address:

Medicare Beneficiary Identifier (MBI):

Insurance Address:

Provider Telephone Number:

Claim Number (ICN):

Insured Name (if applicable):

Contact Name:

Claim Date(s) of Service:

Policy Number:

National Provider Identifier (NPI):

Claim Amount

Group Number:

Provider Number (PTAN):

CPT Code(s):

Injury Date (if applicable):

Tax ID:

Diagnosis Code(s):

Relationship:

Yes, we have a Corporate Integrity Agreement with OIG

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 (Please Explain in the Space Below):	

NOTE: If specific Medicare Number (patient/MBI/Claim #/primary insurance EOB information) is not provided, we may be unable to process your request appropriately or in a timely manner.

PLEASE ATTACH

- Please complete this form and include it with your submission
- Please attach detailed information
- For adjustments that involve multiple patients, please submit a separate form along with the detailed information for each
- Please include a copy of explanation of benefits received from other insurance

Helpful Hints

- If you are sending a refund check, please use the Medicare Part B MSP Voluntary Checks Form
- This form may be utilized for any Medicare Secondary Payer (MSP) request pertaining to Primary or Secondary payment of claims
- Please forward all inquiries for MSP Recovery to the MSP Contractor
- Do not include a refund check with this form
- Do not use this form if you are requesting a Redetermination on a MSP claim that is not MSP related
- Do not use this form for new claim submissions
- Do not use this form for situations that involve the Veteran's Administration. Use Reopenings form.

Please send this form and all additional documentation to:

Fax: (803) 699-3583

or

Palmetto GBA
Medicare Secondary Payer - Part B
P.O. Box 100190
Columbia, SC 29202

MS-JM-B-3000



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