PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Credit Balance Demand Letter Refund Request Form

*ALL fields are **REQUIRED**.*

Provider Name: ____________________ PTAN: ____________________

Contact Person: ____________________ Contact Phone Number: ( ) -

Quarter Ending Date: ____________________

Removal of Medicare Beneficiary Account from 838 Report ☐ Refund Only ☐

Name: (must match CMS838 Report) MBI: (must match CMS838 Report)

ICN#: (must match CMS838 Report) DOS: (must match CMS838 Report)

CR BAL $: (must match CMS838 Report) Refund request for above Medicare Beneficiary Account: Refund Amount: $

Please remove/change from report for reason stated: (reported in error or changes made did not create an overpayment)

(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if refund requested)

Removal of Medicare Beneficiary Account from 838 Report ☐ Refund Only ☐

Name: (must match CMS838 Report) MBI: (must match CMS838 Report)

ICN#: (must match CMS838 Report) DOS: (must match CMS838 Report)

CR BAL $: (must match CMS838 Report) Refund request for above Medicare Beneficiary Account: Refund Amount: $

Please remove/change from report for reason stated: (reported in error or changes made did not create an overpayment)

(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if refund requested)

Removal of Medicare Beneficiary Account from 838 Report ☐ Refund Only ☐

Name: (must match CMS838 Report) MBI: (must match CMS838 Report)

ICN#: (must match CMS838 Report) DOS: (must match CMS838 Report)

CR BAL $: (must match CMS838 Report) Refund request for above Medicare Beneficiary Account: Refund Amount: $

Please remove/change from report for reason stated: (reported in error or changes made did not create an overpayment)

(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if refund requested)

Signature of Office or Administrator of Provider ____________________ Title ____________________ Date (mm/dd/yyyy) / /

FN-HHH-A-2008

Revised 11/2022

Please send this form and all additional documentation via

Fax: (803) 419-3277

If you have any questions, please contact the Provider Contact Center at 855-696-0705