

A CELERIAN GROUP COMPANY





Medicare Credit Balance Demand Letter Refund Request Form

ALL fields are REQUIRED

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

Signature of Office or Administrator of Provider

CR BAL \$: (must match CMS838 Report)

Title

\$

Refund request for above Medicare Beneficiary Account: Refund Amount:



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