

A CELERIAN GROUP COMPANY





Medicare Credit Balance Demand Letter Refund Request Form

ALL fields are REQUIRED

	Provider Name:	PTAN:
Quarter Ending Date: Quarter Ending Date: Quarter Ending Date: Removal of Medicare Beneficiary Account from 838 Report Removal of Medicare Beneficiary Account from 838 Report ICN#: (must match CMS838 Report) ICR 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) ICN#: (must match CMS838 Report) ICN#: (must match CMS838 Report) DOS: (must match CMS838 Report) ICN#: (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) ICN#: (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)		
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(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if refund requested)

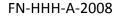
Signature of Office or Administrator of Provider

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