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) ____________________

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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 ____________________ Title ____________________ Date (mm/dd/yyyy)   /   /

FN-JM-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