PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Voluntary Refund Overpayment — Check Enclosed

***ALL** fields are **REQUIRED**.*

For your convenience, submit this form and your payment electronically via the eServices portal located at www.PalmettoGBA.com/eServices or complete this form and mail to the address at the bottom of this form.

Please indicate where the services were provided

☐ North Carolina ☐ South Carolina ☐ Virginia ☐ West Virginia

Provider Information

Provider Name:

Provider Address:

Contact Name:

Contact Direct Telephone & Extension

( ) - x

National Provider Identifier (NPI):

Provider Number (PTAN):

Tax ID:

Patient & Claim Information

Patient Name:

Health Insurance Claim (HIC) Number:

Claim Number (DCN):

Claim Date(s) of Service:

CPT Code(s):

Diagnosis Code(s):

Enclosed Check Information

Enclosed Check Number:

Enclosed Check Amount:

Enclosed Check Date: / /

Overpaid Amount:

☐ **Yes, we have a corporate Integrity Agreement with OIG**

Reason(s) for Overpayment (Please select from the list below)

☐ Billed in Error	☐ Service Not Rendered
☐ Incorrect Service Date (Please provide correct date of service): / /	☐ Modifier Added or Removed (Please provide correction you wish to make):
☐ Duplicate Payment (Please provide correct payment date): / /	☐ Medical Necessity Not Met (Please explain. Attach additional sheet if necessary):
☐ Incorrect CPT Code (Please provide correct CPT code):	☐ Patient Enrolled in HMO (Please indicate which HMO):
☐ Not Our Patient(s) (Please explain circumstance):	

(Please list all claim numbers involved. Attach separate sheet, if necessary.)

Note: If specific patient/HIC/claim amount data is not available for all claims due to statistical sampling, please indicate methodology and formula used to determine amount and reason for overpayment.

Note: If specific patient/HIC/claim # information is not provided, no appeal rights can be afforded with respect to this refund.

PLEASE ATTACH:

- Please complete this form and include it with your submission.
- Please attached detailed information. For overpayments that involve multiple patients, please submit detailed information for each.
- Please enclose the check made payable to Palmetto GBA or Medicare, otherwise the check cannot be accepted for deposit.

Please send this form and all additional documentation to
Palmetto GBA/Medicare
Medicare HHH - Finance & Accounting
P.O. Box 100277
Columbia, SC 29202-3277