



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



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 <input type="checkbox"/>	Refund Only <input type="checkbox"/>
Name: (must match CMS838 Report) <input type="text"/>	MBI: (must match CMS838 Report) <input type="text"/>
ICN#: (must match CMS838 Report) <input type="text"/>	DOS: (must match CMS838 Report) <input type="text"/>
CR BAL \$: (must match CMS838 Report) <input type="text"/>	Refund request for above Medicare Beneficiary Account: Refund Amount: \$ <input type="text"/>
Please remove/change from report for reason stated: (reported in error or changes made did not create an overpayment) <input type="text"/>	
(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if refund requested)	

Removal of Medicare Beneficiary Account from 838 Report <input type="checkbox"/>	Refund Only <input type="checkbox"/>
Name: (must match CMS838 Report) <input type="text"/>	MBI: (must match CMS838 Report) <input type="text"/>
ICN#: (must match CMS838 Report) <input type="text"/>	DOS: (must match CMS838 Report) <input type="text"/>
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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-JJ-A-2008

Please send this form and all additional documentation via

Fax: (803) 870-0147



Revised 11/2022

If you have any questions, please contact the Provider Contact Center at 877-567-7271