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**PALMETTO GBA**  
A CELERIAN GROUP COMPANY



### Medicare Credit Balance Correction And/Or 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:	HIC#:
<input type="text"/>	<input type="text"/>
ICN#:	DOS:
<input type="text"/>	<input type="text"/>
CR BAL \$:	Refund request for above Medicare Beneficiary Account: Refund Amount:
<input type="text"/>	\$ <input type="text"/>
Please remove/change from report for reason stated:	
<input type="text"/>	
(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if Refund Request)	

Removal of Medicare Beneficiary Account from 838 Report <input type="checkbox"/>	Refund Only <input type="checkbox"/>
Name:	HIC#:
<input type="text"/>	<input type="text"/>
ICN#:	DOS:
<input type="text"/>	<input type="text"/>
CR BAL \$:	Refund request for above Medicare Beneficiary Account: Refund Amount:
<input type="text"/>	\$ <input type="text"/>
Please remove/change from report for reason stated:	
<input type="text"/>	
(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if Refund Request)	

Removal of Medicare Beneficiary Account from 838 Report <input type="checkbox"/>	Refund Only <input type="checkbox"/>
Name:	HIC#:
<input type="text"/>	<input type="text"/>
ICN#:	DOS:
<input type="text"/>	<input type="text"/>
CR BAL \$:	Refund request for above Medicare Beneficiary Account: Refund Amount:
<input type="text"/>	\$ <input type="text"/>
Please remove/change from report for reason stated:	
<input type="text"/>	
(Please provide the Medicare EOB's for each Medicare Beneficiary Account, if Refund Request)	

Signature of Office or Administrator of Provider

Title

Date (mm/dd/yyyy)

 /  / 

FN-JM-A-2008



Revised 9/2016

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