Overpayment Notification/Refund Form

Contract: Select One Medicare Type: Select One State:

Billing Provider Name: _____

Address: _____

Billing PTAN: _____ Billing NPI: _____ TIN: _____

Contact Person: _____ Phone Number: _____

For each claim involved, provide the following (attach a separate sheet, if necessary):

Patient Name: _____

Medicare ID: _____

Medicare Claim Number: _____

Date of Service	Procedure Code	Overpaid Amount

Date of Service	Procedure Code	Overpaid Amount
Total Overpaid Amount:		

Reason for Overpayment: Select One

Explanation (if necessary): _____
NOTE: If specific patient/claim#/overpayment amount data is not available for all claims due to statistical sampling, please attach an explanation of the methodology and formula used to determine the amount and reason for overpayment.

For Institutional Facilities Only:

Cost Report Year(s): _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

Please populate the following fields if a payment is submitted with this form:

Amount of Payment: _____ Check #: _____ Check Date: _____

Refund is the result of: Select One
NOTE: If specific patient/claim# information is not provided, no appeal rights can be afforded with respect to this refund. Providers, physicians, suppliers, and other entities who are submitting a refund under the OIG's Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

If no payment included, fax to: (608) 223-7550. If payment included, mail to: WPS GHA, P.O. Box 8550, Madison, WI 53708-8550.