

**This form is not to be used to accompany a check**  
**WPS Medicare Part B MSP**  
**Overpayment Notification Form**

**NOTE:** One claim per form; include the Medicare Remittance Notice

State:  IA    KS  
 MO    NE

Contact Name: \_\_\_\_\_  
Contact Phone Number: \_\_\_\_\_

**Reason for overpayment** (please choose only one):

- Working Aged                       Auto/No Fault  
 ESRD                                       Liability  
 Disability                                 Workers' Compensation

- Federal (Public)  
 Black Lung  
 Workers' Comp. Medicare Set Aside

Billing Provider Name: \_\_\_\_\_  
Billing Provider PTAN: \_\_\_\_\_  
Beneficiary HICN: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_  
NPI Number: \_\_\_\_\_  
Claim Number: \_\_\_\_\_

Date(s) of Service	Procedure Code	Amount Overpaid

Date(s) of Service	Procedure Code	Amount Overpaid
<b>Total Amount Overpaid</b>		

**Medicare Secondary Payer:** Complete the following primary insurance information and **attach a copy of the primary payer EOB.**

**Insurer Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**Policy Information**

Subscriber Name: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Injury Date (if applicable): \_\_\_\_\_ Related Diagnosis: \_\_\_\_\_