

WPS Medicare Part B Non-MSP Refund Form

(Include the check(s) to be refunded and a copy of the remittance notice)

NOTE: A separate form is required for each patient.

From:

Provider/Supplier Name

Address

City, State, Zip Code

PTAN

Tax Identification Number (TIN)

Contact Name

To:

Iowa

WPS Medicare Part B
Financial Unit
P.O. Box 8820
Marion, IL 62959

Kansas

WPS Medicare Part B
Financial Unit
P.O. Box 8830
Marion, IL 62959

Missouri

WPS Medicare Part B
Financial Unit
P.O. Box 8860
Marion, IL 62959

Nebraska

WPS Medicare Part B
Financial Unit
P.O. Box 8850
Marion, IL 62959

Telephone Number

Amount of Check: _____ **Refund Check #:** _____ **Check Date:** _____

Did Medicare Request This Refund? **Yes** **No**

If "Yes", indicate the Accounts Receivable Number (this number is on your letter; please include a copy of your letter) _____

OIG Reporting Requirements:

This refund is the result of a Corporate Integrity Program Yes No
This refund is the result of an OIG Self-Disclosure Program Yes No

Reason Code for Refund...Please check the reason for this refund:

- | | | |
|---|---|--|
| 01 <input type="checkbox"/> Corrected Date of Service | 06 <input type="checkbox"/> Billing Error | 11 <input type="checkbox"/> Patient in SNF |
| 02 <input type="checkbox"/> Duplicate | 07 <input type="checkbox"/> Insufficient Documentation | 12 <input type="checkbox"/> Hospice |
| 03 <input type="checkbox"/> Corrected CPT Code | 08 <input type="checkbox"/> Patient Enrolled in HMO/MCO | 13 <input type="checkbox"/> Veterans' Administration |
| 04 <input type="checkbox"/> Not our Patient(s) | 09 <input type="checkbox"/> Services Not Rendered | 14 <input type="checkbox"/> Other, please specify: _____ |
| 05 <input type="checkbox"/> Mod. Add/Remove | 10 <input type="checkbox"/> Medical Necessity | |

Patient Name: _____ **HICN:** _____ **Date of Service:** _____

Medicare Claim Number (This number is on your remittance): _____

Claim Amount Refunded: _____

NOTE: If specific patient/HICN/claim number 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.

NOTE: If specific patient/HICN/claim number information is not available for all claims due to statistical sampling, please indicate the methodology and formula used to determine amount and reason for overpayment: _____