

This form is not to be used to accompany a check.

**WPS Medicare Part B Non-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 and be specific):

- | | | |
|---|--|--|
| <input type="checkbox"/> Wrong provider paid | <input type="checkbox"/> Services not rendered | <input type="checkbox"/> Corrected date of service |
| <input type="checkbox"/> Assignment error | <input type="checkbox"/> Co-surgeon paid as primary | <input type="checkbox"/> Patient enrolled in a SNF |
| <input type="checkbox"/> Assistant surgeon paid as primary | <input type="checkbox"/> Patient enrolled in HMO/MCO | <input type="checkbox"/> Hospice |
| <input type="checkbox"/> Not our patient | <input type="checkbox"/> Services not covered | <input type="checkbox"/> Veterans' Administration |
| <input type="checkbox"/> Wrong beneficiary paid | | |
| <input type="checkbox"/> Billing error (explain): _____ | | |
| <input type="checkbox"/> Duplicate payment – Original check number: _____ | | |
| <input type="checkbox"/> Other (be specific): _____ | | |

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
Total Amount Overpaid		

Attach any relevant documentation.