Immediate Offset Request

WPS HEALTH INSURANCE®

Medicare Part A

wpsmedicare.com

The following information is required by CMS. Requests submitted with missing information may be returned.

This form should be utilized when requesting an immediate offset of an overpayment for which a demand letter was issued. Please fax the completed form to **Provider Reimbursement at (402) 995-0602**. The request will be processed within two business days of receipt.

Provider Name: _____

Provider Number: _____

Provider NPI: _____

Contact Name: _____

Title: _____

Phone Number: _____

Beneficiary Name	Adjusted DCN No. or AR No.	HIC No.	Dates of Services		Amount Overpaid
			From	To	