AdminaStar Federal Indiana Refund Form

Please send completed form to:

AdminaStar Federal
PCU – Med B – IN
Lockbox #660066
Indianapolis, Indiana 46266-0066

Shall Be Completed By Medicare Contractor

Date: ______________________________

Contractor Deposit Control #: ______________________ **Date of Deposit:** ______________________

Contractor Contact Name: ______________________ **Phone #:** ______________________

Contractor Address: ______________________________

Contractor Fax: ______________________________

Shall Be Completed By Provider/Physician/Supplier, Or Other Entity

Please complete and forward to your Medicare contractor. This form, or a similar document containing the following information, should accompany every unsolicited/voluntary refund so that receipt of check is properly recorded and applied.

Provider/Physician/Supplier or Other Entity Name: ______________________________

Address: ______________________________

Provider/Physician/Supplier #: ______________________ **Tax Id #:** ______________________

Contact Person: ______________________ **Phone #:** ______________________

Amount of Check: $ ____________ **Check #:** ______________________ **Check Date:** ____________

Refund Information:

For each claim, provide the following:

Patient Name: ______________________ **HIC #:** ______________________

Medicare Claim Number: ______________________ **Claim Amount Refunded: $** ______________________

Reason Code for Claim Adjustment: ________ (Select reason code from list below. Use one reason codeper claim.)

Please list all claim numbers involved. Attach separate sheet, if necessary.

Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment: ______________________________

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Note: If specific patient/HIC/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 Office of Inspector General's (OIG's) Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

For Institutional Facilities Only:

Cost Report Year(s): ______________________________

Note: If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? ☐ Yes ☐ No

Are you a participant in the OIG Self-Disclosure Protocol? ☐ Yes ☐ No

Reason Codes

Billing/Clerical:

01 – Corrected Date of Service
02 – Duplicate
03 – Corrected CPT Code
04 – Not Our Patient(s)
05 – Mod. Add/Remove
06 – Billed in Error

MSP/Other Payer Involvement:

07 – MSP Group Health Plan Insurance
08 – MSP No Fault Insurance
09 – MSP Liability Insurance
10 – MSP, Workers Compensation (including Black Lung)
11 – Veterans Administration

Miscellaneous:

12 – Insufficient Doc
13 – Patient Enroll HMO
14 – Services Not Rendered
15 – Medical Necessity
16 – Other: Please Specify ____________

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