noridian
Healthcare Solutions

DME JA Non-MSP Voluntary Refund Checks Form (Check Enclosed)

Note: Do not use this form for MSP refunds.

This form should accompany every unsolicited/voluntary refund check. Complete and mail this form along with a check to the address listed on the bottom of this form. To request an adjustment without submitting a check, select the Non-MSP Overpayment Request option on the Forms page at https://med.noridianmedicare.com/web/jadme/forms.

Please do not include MSP or Demanded refunds with your non-MSP Voluntary check.
Please include the following check information: Make your check payable to Medicare DME.

Check Number: _____ Check Date: _____

Reason for Refund (For OIG Reporting Requirements)
☐ Corporate Integrity Program ☐ OIG Self Disclosure Protocol ☐ Voluntary Refund

Required Information: Please provide the following refund information for each claim.

Claim Control Number (CCN)	Beneficiary Name	Medicare Number	Date of Service	Dollar Amount to be refunded	HCPCS Code to be refunded	Reason Code
			Total	0.00		

For additional claims please use the spreadsheet located at https://med.noridianmedicare.com/web/jadme/forms.

If the number of claims doesn't fit please include a spreadsheet.
REASON CODE FOR CLAIM ADJUSTMENT

Billing/Clerical
1 ☐ Corrected Date of Service _____
2 ☐ Duplicate
3 ☐ Corrected CPT code _____
4 ☐ Corrected modifier _____
5 ☐ Billed in error (please specify) _____
6 ☐ Same/similar equipment
7 ☐ Not our patient/billing error
8 ☐ Services after date of death

Miscellaneous
9 ☐ Insufficient documentation
10 ☐ Services not rendered
11 ☐ Medical necessity
12 ☐ Paid wrong provider
13 ☐ Non-covered service
14 ☐ Returned/picked up date: _____
15 ☐ Units change: _____
16 ☐ Other (please specify) _____

Other Payer Involvement
17 ☐ Patient in SNF
18 ☐ Inpatient
19 ☐ Patient in HMO
20 ☐ Patient in HHA
21 ☐ Patient in Hospice

Supplier Information:
Supplier name: _____
Address: _____ City: _____ State: _____ Zip: _____
PTAN and/or NPI Number: _____ Tax ID#: _____
Contact Person: _____
Telephone Number: _____ Ext.: _____ Fax Number: _____ Ext: _____

Note: If specific patient/claim Number information is not provided, no appeal rights can be afforded with respect to this refund. Providers/physicians and other entities that are submitting a refund under an OIG Self-Disclosure Protocol are not afforded appeal rights as stated in the signed agreement presented by the OIG.

Please send this form **along with a check** to: Noridian JA DME
Attn: Refunds
PO Box 511470
Los Angeles, CA 90051-8025

The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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