FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

RETURN OF MONIES VOLUNTARY REFUND FORM

This form should be completed fully and accompany each unsolicited/voluntary refund check so that your refund can be properly recorded and applied.

Provider or Other Entity Name

Address State:

Provider Number NPI #

Contact Person Tax ID #

Contact Person Phone #

Amount Returned Check #

Required Information If Multiple Claims indicate "YES" and include listing

*Patient Name *Medicare ID #

*Claim Number Claim Amount Refunded

Date of Service From Date of Service To

Reason Code for Claim Adjustment Claim Billed Amount

Additional Info. field

OIG Reporting Requirements

Do you have a corporate integrity agreement with OIG?

Are you a participant in the OIG self-disclosure protocol?

Note: Providers 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.

MSP Information

Other Insurer Information

Insurance Co. Name

Subscriber Name

Insurer Address Line 1

Insurer Address Line 2

City State Zip

Telephone Number

Employer Information

Employer Name

Employer Address Line 1

Employer Address Line 2

City State Zip

Policy #

Telephone Number

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Instructions

- For each claim the required fields to be completed on the form are noted with *. If the required fields for specific Patient/MBI & Claim Numbers are not completed, NO appeal rights can be provided for this voluntary refund.
- **Multiple Claims being refunded:** If refunding multiple claims, list all claim numbers and the required data on separate forms if necessary.
- **Medicare Secondary Payment (MSP) Refunds:** Include a copy of the primary insurer's explanation of benefit (EOB) & indicate the MSP reason (see Reason Code List Below)
- **Statistical Sampling:** If specific Beneficiary/MBI/Claims data is not available, indicate the methodology and formula used to determine the refund amount and explain the reason for the refund

Make check payable to **Medicare Part A** or **Medicare Part B**. Mail To **First Coast Service Options CASHIER** at Address listed below according to state services rendered:

State - LOB	PO Box	City	State	ZIP
FL, PR, VI - A	PO Box 3162	Mechanicsburg,	PA	17055-1837
FL - B	PO Box 3092	Mechanicsburg,	PA	17055-1810
PR & VI – B	PO Box 3121	Mechanicsburg,	PA	17055-1831

Reason Codes for each Claim Incorrect Payment (Required to Select One Reason code per refunded claim on Form):

Billing/Clerical/Non-MSP

01 - Corrected Date of Service Date Required
02 - Duplicate
03 - Corrected CPT Code Correct CPT Code Required
04 - Not Our Patient
05- Mod. Add/Remove
06- Billed in Error

MSP/Other Payer Involvement

07- MSP Group Health Plan Insurance
08- MSP No Fault Insurance Date of Incident Required
09- MSP Liability Insurance Date of Incident Required
10- MSP, Workers Comp (including Black Lung) Date of Incident Required

Miscellaneous

11- Veterans Administration
12- Insufficient Data
13- Patient Enroll HMO
14- Svcs Not Rendered
15- Medical Necessity
16- Hospice
17-Other-Please Specify: Description Required

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Provider or Other Entity Name – Provider/Physician/Supplier/Entity Name

Address - Provider/Physician/Supplier/Entity Address **State** – State services rendered in

Provider Number – Provider Transaction Access Number

NPI # - National Provider Identifier Number (10 digits)

Tax ID # - Provider Tax Identification Number

Contact Person – Name of person to contact if additional information is required

Contact's Phone # - Phone number of contact person if additional information is required

Amount Returned – Total amount of voluntary refund check

Check # - Check number of voluntary refund check

Required Information – If returning Multiple Claims, indicate "YES" in box provided. Include listing of claims with Required Information with check.

Patient Name – Name of patient on claim for which money is being voluntarily returned (Required for Appeal rights)

Medicare ID # - Medicare Beneficiary Identification # on claim for which money is being voluntarily returned (Required for Appeal rights).

Claim Number – Claim Number for which money is being voluntarily returned (Required for Appeal rights)

Claim Amount Refunded – Amount voluntarily returned for specific claim listed

Date of Service From – Date services started for specific claim listed

Date of Service To – Date services ended for specific claim listed

Reason Code for Claim Adjustment – Select appropriate reason code listed under "Reason Codes for each Claim Incorrect Payment"

Claim Billed Amount – Original Billed amount for specific claim listed

Additional Info. Field – To be populated when Reason Codes 01, 03, 08, 09, 10 or 17 are selected.

OIG Reporting Requirements – Select Yes or No to each question.

MSP Information Other Insurer Information (Required if Reason Codes 08, 09 or 10 selected)

Insurance Co. Name – Name of Insurance Company that should have paid as primary.

Subscriber Name – Name of Subscriber to insurance that should have paid as primary.

Insurer Address – Address of Insurance Company that should have paid as primary

City/State/ZIP – City/State/ZIP of Insurance Company that should have paid as primary

Telephone Number – Telephone Number of Insurance Company that should have paid as primary

Employer Information (If Primary Insurance is Provided by Employer)

Employer Name - Name of employer that provided Primary Insurance

Employer Address - Address of employer that provided Primary Insurance

City/State/ZIP – City/State/ZIP of employer that provided Primary Insurance

Policy # - Policy # of Primary Insurance

Telephone Number - Telephone of employer that provided Primary Insurance