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

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.

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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

Mail To **First Coast Service Options CASHIER** at Address listed below according to state services rendered:

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