

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 405	Date: November 21, 2008
	Change Request 6247

SUBJECT: FISS Reason Code Language Expansion

I. SUMMARY OF CHANGES: This Change Request instructs the FISS maintainer, HIGLAS and the contractors to establish clearer, more detailed explanations and/or definitions of the current reason codes in the demand letters.

New / Revised Material

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 405	Date: November 21, 2008	Change Request: 6247
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SUBJECT: FISS Reason Code Language Expansion

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

I. GENERAL INFORMATION

A. Background: Section 1893(f) (2), added by Section 935(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires CMS to change the way Medicare recoups certain overpayments. Change Request (CR) 6183-Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments, instructs the contractors to include in the demand letters a detailed reasoning of why the overpayment was established. Currently, the reason codes housed in the FISS system do not give meaningful definition or description for these overpayments.

To establish clearer definitions to be included in the demand letters the FISS maintainer, HIGLAS and the contractors shall define and explain the current reason codes to be more robust in explanation.

B. Policy: This CR does not constitute policy to implement the limitation on recoupment. It is one of a series of CRs that are being or have been issued designed to fully implement section 1893(f) (2) and the final implementing regulation when published and in effect.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)								
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6247.1	The FISS maintainer shall take current reason code language and elaborate on its definition. This language shall be written in the demand letters.						X			
6247.1.1	The FISS maintainer shall take current reason code language and give a generic reason or scenario of why the overpayment was established. <u>Example:</u> <u>Current Language:</u> AUPROV – Automobile <u>Revised Language:</u> AUPROV or Medicare Secondary Payer -						X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER	
							F I S S	M C S	V M S	C W F		
	Automobile – The claim was processed and paid with Medicare as the primary coverage. Medicare should have paid secondary to automobile coverage.											
6247.2	The HIGLAS system shall allow for the appropriate language to be written in the demand letter.											HIGLAS
6247.2.1	HIGLAS shall house these reason codes and definitions in the HIGLAS system.											HIGLAS
6247.3	The contractors shall select the appropriate reason code as it relates to the reason why the overpayment has been established.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER	
							F I S S	M C S	V M S	C W F		
	None.											

IV. SUPPORTING INFORMATION

X-Ref Requirement Number	Recommendations or other supporting information:

V. CONTACTS

Pre-Implementation Contact(s):

Theresa S. Jones-Carter
theresa.jones-carter@cms.hhs.gov
410-786-7482

Post-Implementation Contact(s):

Theresa S. Jones-Carter
theresa.jones-carter@cms.hhs.gov
410-786-7482

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) and Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs):*

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

2 Attachments

MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<BODY_LEFT>	310.00
MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<BLANK>	330.00
MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<CLOSING_LEFT>	340.00
MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<BLANK>	341.00
MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<BLANK>	350.00
MNGWC1	Worker's Compensation Demand Letter	VERSION 3	Updated as part of MNT# 29907900	10/25/2006	<BLANK>	360.00

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Letter Number: &LETTER_NUMBER
[b]Date: &LETTER_DT[/b]

[b]&ADDRESSEE_NAME[/b]
[b]&ADDRESSEE_ADDRESS1[/b]
[b]&ADDRESSEE_ADDRESS2[/b]
[b]&ADDRESSEE_CITY, &ADDRESSEE_STATE &ADDRESSEE_POSTAL_CODE[/b]

Letter Number: &LETTER_NUMBER
[b] Date: &LETTER_DT [/b]

[b] &ADDRESSEE_NAME [/b]
[b] &ADDRESSEE_ADDRESS1 [/b]
[b] &ADDRESSEE_ADDRESS2 [/b]
[b] &ADDRESSEE_CITY, &ADDRESSEE_STATE &ADDRESSEE_POSTAL_CODE [/b]

[b]&LETTER_DT [/b]

[b] &DEBTOR_NAME [/b]
[b] &DEBTOR_ADDRESS1 [/b]
[b] &DEBTOR_ADDRESS2 [/b]
[b] &DEBTOR_CITY, &DEBTOR_STATE, &DEBTOR_POSTAL_CODE [/b]

Re:Employee Name: [b] &LBENEFICIARY_NAME [/b]
HIC #: [b] &LHIC_NUMBER [/b]
Date of Incident: [b] &LDATE_OF_SERVICE_FROM [/b]
Debt Identification No.: [b] &CASE_NUMBER [/b]
Demand Amount: \$[b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam:

Medicare has determined that you are required to reimburse the Medicare program for amounts it paid for items or services relating to your [b] [CMS Identified Group Class Description] [/b] and other medical conditions for which you s

A list of the payments the Medicare program made to you or on your behalf is enclosed. The Medicare program paid \$[b] &DEMAND_AMOUNT [/b] for items and services related to your [b] [CMS Identified Group Class Description] [/b]

[b] [Allow the user to select which paragraph they want inserted into the body of the letter] [/b]

[b]Insert #1[/b]

We have reduced this amount to [*] in accordance with 42 C.F.R. 411.37 to reflect the costs you incurred to procure the settlement, judgment, or award.

[b]Insert #2[/b]

We did not reduce this amount to reflect the costs you incurred to procure the settlement, judgment, or award because you have not provided us with the required information to enable us to make the adjustment in accordance with 42

[b]Insert #3[/b]

This demand relates to proceeds you are receiving in the Revised Settlement Program, [b] [Name of CMS Identified Group Class] [/b] in connection with your current claim, for which you received a Notification of Status from the Claims

[b]Insert #4[/b]

This demand relates to proceeds you [b][?]/[b] in [b][?]/[b]. If, in the future, you receive additional funds from this settlement, judgment, or award, or any other your [b][CMS Identified Group Class Description]/[b] judgment, or award

You must pay this amount \$[b] &DEMAND_AMOUNT [/b] within sixty (60) days of the date of this letter (by [b]&LETTER_DATE_59[/b]). Please send a check or money order in the amount of \$[b] &DEMAND_AMOUNT [/b] made payable

If you do not pay this amount by [b]&LETTER_DATE_59 [/b], you will be required to pay interest from the date of this letter. Interest will be calculated at the rate of [b]&AR_INTEREST_RATE% [/b] per annum in accordance with 42 C.

If you do not pay this amount, the Medicare program may recover the amount from any Social Security or Railroad Retirement benefits to which you might otherwise be entitled, or the money may be recouped from payments Medicare

If you are unable to pay this amount in one payment, you may ask us to consider whether to allow you to pay in regular installments. (Any installment payments are applied to accrued interest first and then to the remaining principal.)

You have the right to question the amount you are required to repay if you believe the amount includes costs for services that are not related to your breast implant settlement, judgment, or award. Please be aware that you are requir

[b]Insert #5[/b]

Medicare is aware that a number of breast implant manufacturers have made settlements which include payment for connective tissue and autoimmune type illnesses and injuries in connection with the breast implants they have manuf

However, it is important that you understand that Medicare will subtract the Medicare payment amounts for such items or services from its demand if you can establish that you did not claim and/or recover for such illnesses or injuries.

This determination that you must refund Medicare is subject to the waiver of recovery and appeal rights explained below. However, if you believe that this amount is incorrect and submit the kind of information described in the precedi

[b]Insert #6[/b]

your [b] [Name of CMS Identified Group Class] [/b] clearly sets forth the illnesses and injuries for which it makes payment. Medicare has used the Notification of Status document you received and the Revised Settlement Agreement in

You have the right to request that the Medicare program waive its recovery in whole or in part. The Medicare program may waive its recovery if [b]both[/b] of the following conditions are met:

1. This overpayment (for purposes of requesting waiver of recovery, the amount you owe is considered an overpayment), was not your fault, because the information you gave us with your claims for Medicare benefits was correct and

[b][u]AND[/u][b]

2. Paying back this money would cause financial hardship [b]OR[/b] would be unfair for some other reason.

If you believe that [b>BOTH[/b] of the conditions above apply in your case, you should make a written request for waiver of recovery of the overpayment within thirty (30) days of the date of this letter, giving a brief statement of your r

You may appeal our determination that you owe \$[b] &DEMAND_AMOUNT [/b] related to your [b] [CMS Identified Group Class Description] [/b] settlement; judgment, or award. For Part A services, you must appeal within sixty (60) da

If you decide to appeal this determination further, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as la

If you have any questions, please contact the Contractor.

Sincerely,

[b] &CLOSING_NAME [/b]
&DUMM1
Letter Number: &LETTER_NUMBER
Date: &LETTER_DT

[b] &DEBTOR_NAME [/b]
[b] &DEBTOR_ADDRESS1 [/b]
[b] &DEBTOR_ADDRESS2 [/b]
[b] &DEBTOR_CITY, &DEBTOR_STATE, &DEBTOR_POSTAL_CODE [/b]

[b] &LETTER_DT [/b]

[b]&HPROVIDER_NAME[/b]
[b]&HPROVIDER_ADDRESS1[/b]
[b]&HPROVIDER_ADDRESS2[/b]
[b]&HPROVIDER_CITY, &HPROVIDER_STATE, &HPROVIDER_POSTAL_CODE[/b]

[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Sincerely,

MSP Supervisor

Enclosure:
Payment Summary Form
Letter Number: &LETTER_NUMBER
[b]Date: &LETTER_DT[/b]

[b]&HINSURER_NAME[/b]
[b]&HINSURER_ADDRESS1[/b]
[b]&HINSURER_ADDRESS2[/b]
[b]&HINSURER_CITY, &HINSURER_STATE &HINSURER_POSTAL_CODE[/b]

[b] &DEBTOR2_NAME [/b]
[b] &DEBTOR2_ADDRESS1 [/b]
[b] &DEBTOR2_ADDRESS2 [/b]
[b] &DEBTOR2_CITY, &DEBTOR2_STATE &DEBTOR2_POSTAL_CODE [/b]

Debt Identification No: [b]&CASE_NUMBER [/b]
Demand Amount: [b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam,

We are writing to advise you that your organization is liable or shares liability for a debt to the Medicare program. The followin

[b] [u]How This Happened[/u] [/b]

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to Medicare beneficiar

CMS is required under the Medicare law to recover primary payments that Medicare mistakenly made when a group health plan

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized in enclosures to this let

Your failure to respond as requested within sixty (60) days of the date of this letter may result in the initiation of additional rec

If you fail to pay this debt to Medicare or otherwise resolve this matter within 60 days of the date of this letter, interest is due

If you fail to repay Medicare or provide the information requested to rebut the debt to Medicare, Medicare may also determine

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, please see 42 U.S

If you have any questions concerning this matter, please write [b]&CONTRACTOR_NAME[/b] or call [b]&CONTRACT_STATE_T

When you are enclosing payments, please make the check payable to [b]&CONTRACTOR_NAME[/b]. Mail the check and any in

[b]&CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Sincerely,

MSP Supervisor

Enclosures:
How to Resolve This Demand
Important Information for Employers
Payment Summary Form
Letter Number: &LETTER_NUMBER
[b]Date: &LETTER_DT[/b]

[b]&DEBTOR_NAME[/b]
[b]&DEBTOR_ADDRESS1[/b]
[b]&DEBTOR_ADDRESS2[/b]
[b]&DEBTOR_CITY, &DEBTOR_STATE &DEBTOR_POSTAL_CODE[/b]

[b]&DEBTOR2_NAME[/b]
[b]&DEBTOR2_ADDRESS1[/b]
[b]&DEBTOR2_ADDRESS2[/b]
[b]&DEBTOR2_CITY, &DEBTOR2_STATE &DEBTOR2_POSTAL_CODE[/b]

Debt Identification No.: [b]&CASE_NUMBER[/b]

[b]Past-due debt owed CMS by &DEBTOR_NAME as of &LETTER_DT [/b]

[b]Joint & Several: &DEMAND_AMOUNT [/b]
[b]Individual: &TOTAL_LIABILITY_FOR_EMPLOYER [/b]
[b]Total Due: &TOTAL_LIABILITY_FOR_EMPLOYER [/b]

[b]Past-due debt owed CMS by &DEBTOR2_NAME as of &LETTER_DT [/b]

[b]Joint & Several: &DEMAND_AMOUNT [/b]
[b]Individual: &TOTAL_LIABILITY_FOR_INSURER [/b]
[b]Total Due: &TOTAL_LIABILITY_FOR_INSURER [/b]

Date debt became past-due: [b]&DATE_OF_ORIG_DEMAND_LETTER_60 [/b]

Date of Demand Letter previously sent: [b] &DATE_OF_ORIGINAL_DEMAND_LETTER [/b]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED D

Dear Sir/Madam:

(Please note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the r

The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) has determin

This demand letter is being issued to the parties of the original demand letter (copy enclosed). If the amount shown as past due debt arose under the Medicare Secondary Payer (MSP) provisions of the Social Security Act. CMS has the right to collect this debt. The purpose of this notice is to inform both of your organizations that your debt may be referred to Treasury and/or a designated agent. Please read the following instructions carefully as they may assist both of your organizations in resolving this matter prior to referral.

[b] [u] Challenging the Indebtedness: [u] [b]
You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the designated agent.

The portion of the debt, for which you are mutually responsible, will not be referred for further collection action if your organization pays the past-due debt, for which you are jointly and severally responsible, owed to CMS as of [b]&LETTER_DT[/b], including interest.

In addition, to the past-due debt, for which you are jointly and severally responsible, owed to CMS, [b]&DEBTOR_NAME[/b] is included in the demand letter.

Please be aware that if you paid the provider, physician, or other supplier for the claims at issue after Medicare issued its demand letter, you may be liable for the debt.

[b] &CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Your check should also include the Debt Identification No. as shown at the beginning of this letter in order to ensure that your payment is applied to the correct debt.

If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement.

[b] [u]Bankruptcy Related Information[/u] [b]: If you have filed for bankruptcy [u]and[/u] an automatic stay of bankruptcy is in effect, you may be able to request a discharge of the debt.

If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may contact the designated agent.

Sincerely,

MSP Supervisor

Enclosures:
How to Resolve This Demand
Important Information for Employers
Payment Summary Form
Letter Number: &LETTER_NUMBER
[b] Date: &LETTER_DT [b]

[b] &DEBTOR_NAME [/b]
[b] &DEBTOR_ADDRESS1 [/b]
[b] &DEBTOR_ADDRESS2 [/b]
[b] &DEBTOR_CITY, &DEBTOR_STATE &DEBTOR_POSTAL_CODE [/b]

&CONTRACTOR_NAME
&CONTRACTOR_NAME
&FOOTER_ADDRESSEE
&FOOTER_ADDRESSEE

&FOOTER_ADDRESS1, &FOOTER_CITY, &FOOTER_STATE &FOOTER_POSTAL_CODE
&FOOTER_ADDRESS1, &FOOTER_CITY, &FOOTER_STATE &FOOTER_POSTAL_CODE
&CONTRACTOR_URL
&CONTRACTOR_URL

[b] &LETTER_HEADER1 [b]
[b] &LETTER_HEADER1 [b]
&LETTER_HEADER2
&LETTER_HEADER2

&LETTER_HEADER3
&LETTER_HEADER3
&LETTER_HEADER4
&LETTER_HEADER4

Name: [b] &HBENEFICIARY_NAME [b]
HIC#: [b] &HHIC_NUMBER [b]
Date of Incident: [b] &MSP_EFFECTIVE_DATE [b]

Debt Identification No.: [b] &CASE_NUMBER [b]
Demand Amount: [b] &DEMAND_AMOUNT [b]

Dear Sir/Madam:

We are writing to you because we recently learned that you made a liability claim relating to an illness, injury or incident occurring on or after [b] &LETTER_DT [b].

We hope that you will find answers to some of the questions you may have about this letter below. Parts I and II of this letter address the following questions:

[b] I. Why am I required to repay Medicare? [b]
You are required to repay Medicare because Medicare paid for medical care you received related to your liability recovery. The amount of the debt is the amount of Medicare's payment for the medical care.

If you would like to read the MSP law, you can find it in Title 42 of the United States Code, Section 1395y(b)(2). You can also find the law at www.gpo.gov.

[b] II. How did Medicare decide how much money I owe? [b]
The Medicare program paid [b] >_CONDITIONAL_PAYMENT_AMOUNT [b] for medical care related to your liability recovery. This letter relates only to money paid from your current recovery. If, in the future, you receive additional money from this liability recovery, you may be able to request a refund of the amount you owe.

[b] III. What do I need to do to repay Medicare the amount I owe? [b]
You must repay Medicare [b] &DEMAND_AMOUNT [b] within sixty (60) days of the date of this letter (by [b] &LETTER_DATE_55 [b]).

[b] IV. What rights do I have if I disagree with the amount this letter says I owe or think that I should not have to pay Medicare? [b]

[u]Right to Request a Waiver.[u] You have the right to request that the Medicare program waive recovery of the amount you owe if you can show that:

1. This overpayment (for purposes of requesting waiver of recovery, the amount you owe is considered an overpayment), was not your fault, and

2. Paying back this money would cause financial hardship or would be unfair for some other reason.

If you believe that [b] both [/b] of these conditions apply to you, you should send us a letter that explains why you think you s E
E
[u] Right to Appeal. [/u] You also have the right to appeal our determination if you disagree that you owe Medicare as explain E
E
If your appeal relates to Part A services, you will need to mail your request within 120 days from the date you receive this lette E
E
If you want help with your appeal or request for waiver, you can have a friend, lawyer, or someone else help you. Some lawye E
E
[b] V. What happens if I do not repay Medicare the amount I owe? [/b] E
E
Please note that, if you do not repay Medicare in full by [b] &LETTER_DATE_59 [/b], you will be required to pay interest on any E
E
If you are unable to repay Medicare in one payment, you may ask us to consider whether to allow you to pay in regular installm E
E
You should also be aware that if you do not repay Medicare in full, it may decide to recover any amounts you owe (including ac E
E
[b] VI. Who should I contact if I have questions about this letter? [/b] E
E
This office is the Medicare contractor responsible for handling your case. If you have any questions about this letter, or questio E
E
Sincerely, E
E

MSP Supervisor

[b]&CONTRACTOR_NAME [/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

cc: [b]&CC_NAME[/b]

Enclosure:
Payment Summary Form
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

[b]PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME[/b]

Date: &LETTER_DT

[b] &ADDRESSEE_NAME [/b]
[b] &ADDRESSEE_ADDRESS1 [/b]
[b] &ADDRESSEE_CITY, &ADDRESSEE_STATE, &ADDRESSEE_POSTAL_CODE [/b]

Name of Beneficiary: [b] &HBENEFICIARY_NAME [/b]
HIC #: [b] &HHIC_NUMBER [/b]
Date of Injury/Illness/Incident: [b] &CASE_EFFECTIVE_DATE [/b]

Dear Sir/Madam:

[b] [u] Please note that if we know that you have an attorney or other individual representing you in this matter, we are sendir E
E
This communication follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined unde E
E
[b]However, we request that you/your attorney refrain from sending any monies to Medicare prior to submission of settlement E
E
Currently, Medicare has paid [b]&DEMAND_AMOUNT[/b] in conditional payments related to your claim. Attached you/your attc E
E
[b]Please be advised that we are still investigating this case file to obtain any other outstanding Medicare conditional payments E
E
If the case has settled, please furnish our office with a copy of:

The settlement agreement from the third party payer showing the total amount of the settlement, signed and dated by your cl E
E
Your closing statement reflecting the actual amount of the attorney's fees and costs (excluding medical bills)

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact r E
E

Sincerely,

&ELECTRONIC_SIGNATURE

MSP Supervisor
[b] &CONTRACTOR_NAME [/b]

Enclosure: Payment Summary Form

cc: [b]&CC_NAME[/b]

Name: [b] &HBENEFICIARY_NAME[/b]
HIC#: [b] &HHIC_NUMBER [/b]
Date of Incident: [b] &MSP_EFFECTIVE_DATE [/b]
Debt Identification No.: [b] &CASE_NUMBER [/b]
Demand Amount: [b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam :

This letter follows our earlier communication in which we advised you that you would have to repay Medicare for services paid E
E
The Medicare Secondary Payer provisions of the statute, 42 U.S.C. 1395y(b) (2), preclude Medicare from paying for a beneficia E
E
Medicare's regulations require that you pay Medicare within 60 days of your receipt of settlement or insurance proceeds. There E
E

[b] &CONTRACTOR_NAME [/b]
[b] &MSP_ADDRESS1 [/b]

[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Exercising Common Law authority and consistent with the Federal Claims Collection Act, interest will be assessed if this debt is
If the amount repaid for any services that appear on the enclosed payment summary is less than the amount that Medicare paid

If you have any questions about this letter, you may contact [b] &CONTRACTOR_NAME [/b] at [b] &CONTRACT_STATE_TOLL

Sincerely,

MSP Supervisor

Enclosure:
Payment Summary Form
Letter Number: &LETTER_NUMBER
Invoice Number: &HINVOICE_NUMBER
&LETTER_DT
&CONTRACTOR_NAME
&LBENEFICIARY_NAME
&HINVOICE_NUMBER
&LHIC_NUMBER
&HMSP_TYPE
&MSP_EFFECT_DATE_COV_BEGIN_DATE
&TYPE_OF_SERVICE
&LCLAIM_NUMBER
&LINE_NUMBER
&PROCESSING_CONTRACTOR_NUMBER
&LBILL_PROVIDER_NAME
&DIAGNOSIS_CODE
&LDATE_OF_SERVICE_FROM
&LDATE_OF_SERVICE_TO
&TOTAL_LINE_CHARGES
&REIMBURSED_AMOUNT
&CONDITIONAL_PAYMENT_AMOUNT
&TOT_CONDITIONAL_PAYMENT_AMOUNT

Debt Identification No: [b] &CASE_NUMBER [/b]
Demand Amount: [b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam:

We are writing to advise you that your organization either has sole liability or shares liability for a debt to the Medicare program

[b][u] How This Happened [/u][b]

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to the Medicare beneficiary

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the primary payer

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information is attached.

Total Repayment Requested [b] &DEMAND_AMOUNT [/b]

[b][u] How to Resolve This Matter [/u][b]

Within 60 days of the date of this letter, you or someone acting on your behalf; e.g., your insurer or plan administrator, must pay the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan.

Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan.

If the group health plan is not obligated to make primary payment under any circumstances for services provided to an identified Medicare beneficiary,

If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified Medicare beneficiary is not stated in the summary sheet, you must provide the basis.

If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare regulations, as a denial.

Dates of coverage under the group health plan are shown on the enclosed summary sheet. If you believe the dates listed are incorrect, you must provide the correct dates.

Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibilities under the Medicare program.

If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will file a claim against your organization.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will determine this is set forth in the summary sheet.

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, see 42 U.S.C. 1395cc(a)(2)(B).

If you have any questions concerning this matter, please write [b]&CONTRACTOR_NAME[/b] or call [b]&CONTRACT_STATE_TOLL[/b].

When you are enclosing payments, please make the check payable to [b] &CONTRACTOR_NAME [/b]. Mail the check and any other documents to the address below.

[b] &CONTRACTOR_NAME [/b]
[b]Attention: MSP Unit[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Sincerely,

MSP Supervisor

Enclosures:
Important Information for Employers
Payment Summary Form

Letter Number: &LETTER_NUMBER
[b]Date: &LETTER_DT[/b]

[b] &ADDRESSEE_NAME [/b]

[b] &ADDRESSEE_ADDRESS1 [/b]
[b] &ADDRESSEE_ADDRESS2 [/b]
[b] &ADDRESSEE_CITY, &ADDRESSEE_STATE &ADDRESSEE_POSTAL_CODE [/b]

Past-due debt owed CMS as of [b]&LAST_INTEREST_ACCRUAL_DATE: &DEMAND_AMOUNT[/b]

Date debt became past-due: [b]&DATE_OF_ORIG_DEMAND_LETTER_60[/b]

Date of Demand Letter previously sent: [b]&DATE_OF_ORIGINAL_DEMAND_LETTER[/b]

Taxpayer Identification Number (TIN): [b]&DEBTOR_EIN[/b]

Debt Identification No.: [b]&CASE_NUMBER[/b]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED D

Dear Sir/Madam:

(Please note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the r

The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) has determine

The purpose of this notice is to inform you that your debt may be referred to Treasury/a designated DCC, under the provisions

Please read the following instructions carefully as they may assist you in resolving this matter prior to referral. Please note that

[b] [u]Challenging the Indebtedness:[/u] [/b]

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted i

Your debt will not be referred for further collection action if you make payment in full. Please be advised that payment of princ

The past-due debt owed to CMS as of [b]&LETTER_DT[/b], including interest accrued through [b] &LAST_INTEREST_ACCRUAL

[b]&CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Your check should also include the "debt identification numbers" as shown at the beginning of this letter in order to ensure tha

If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement.

[b][u]Bankruptcy Related Information[/u] [/b]: If you have filed for bankruptcy [u]and[/u] an automatic stay of bankruptcy is i

[b][u]Information for Individual Debtors Filing a Joint Federal Income Tax Return[/u] [/b]: TOP automatically refers debts to th

If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may

If you call, please be sure that you have this letter available so that you can readily provide us with the identification informati

Sincerely,

MSP Supervisor

Enclosures:

Supplemental Information on Resolving Debts

Payment Summary Form

Past-due debt owed CMS as of [b] &LAST_INTEREST_ACCRUAL_DATE : &DEMAND_AMOUNT [/b]

Date debt became past-due: [b] &DATE_OF_ORIG_DEMAND_LETTER_60 [/b]

Date of Demand Letter previously sent: [b] &DATE_OF_ORIGINAL_DEMAND_LETTER [/b]

Taxpayer Identification Number (TIN): [b] &DEBTOR_EIN [/b]

Beneficiary's Name: [b] &HBENEFICIARY_NAME [/b]

Beneficiary's HIC#: [b] &HHIC_NUMBER [/b]

Date of Accident/Incident: [b] &MSP_EFFECTIVE_DATE [/b]

Debt Identification No.: [b] &CASE_NUMBER [/b]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED D

Dear Sir/Madam:

(Please note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the r

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The purpose of this notice is to inform you that your debt may be referred to Treasury/a designated DCC, under the provisions

Please read the following instructions carefully as they may assist you in resolving this matter prior to referral.

[b] [u]Challenging the Indebtedness:[/u] [/b]

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted i

Your debt will not be referred for further collection action if you make payment in full. Please be advised that payment of princ

The past-due debt owed to CMS as of [b]&LETTER_DT[/b], including interest accrued through [b]&LAST_INTEREST_ACCRUAL

[b]&CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Your check should also include the "debt identification numbers" as shown at the beginning of this letter in order to ensure tha

If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement.

[b] [u]Bankruptcy Related Information[/u] [/b]: If you have filed for bankruptcy [u]and[/u] an automatic stay of bankruptcy is E
E
[b] [u]Information for Individual Debtors Filing a Joint Federal Income Tax Return[/u] [/b]: TOP automatically refers debts to the E
E
If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may E
E
If you call, please be sure that you have this letter available so that you can readily provide us with the identification information E
E
Sincerely, E
E
E
E
MSP Supervisor E
E
E
Enclosures: E
Payment Summary Form E
Past-due debt owed CMS as of [b] &LAST_INTEREST_ACCRUAL_DATE : &DEMAND_AMOUNT [/b] E
E
Date debt became past-due: [b] &DATE_OF_ORIG_DEMAND_LETTER_60 [/b] E
E
Date of Demand Letter previously sent: [b] &DATE_OF_ORIGINAL_DEMAND_LETTER [/b] E
E
Taxpayer Identification Number (TIN): [b] &DEBTOR_EIN [/b] E
E
Beneficiary's Name: [b] &HBENEFICIARY_NAME [/b] E
Beneficiary's HIC#: [b] &HHIC_NUMBER [/b] E
Date of Accident/Incident: [b] &MSP_EFFECTIVE_DATE [/b] E
Debt Identification No.: [b] &CASE_NUMBER [/b] E
E

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEPARTMENT E
E
Dear Sir/Madam: E

(Please note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the request. E
E
The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) has determined E
E
The purpose of this notice is to inform you that your debt may be referred to Treasury/a designated DCC, under the provisions of E
E
Please read the following instructions carefully as they may assist you in resolving this matter prior to referral. E

[b] [u]Challenging the Indebtedness[/u] [/b] E
You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in E
E
Your debt will not be referred for further collection action if you make payment in full. Please be advised that payment of principal E
E
The past-due debt owed to CMS as of [b] &LETTER_DT[/b], including interest accrued through [b] &LAST_INTEREST_ACCRUAL_DATE E
E
[b] &CONTRACTOR_NAME[/b] E
[b] &MSP_ADDRESS1 [/b] E
[b] &MSP_ADDRESS2 [/b] E
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b] E

Your check should also include the "debt identification numbers" as shown at the beginning of this letter in order to ensure that the E
E
If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement. E

[b] [u]Bankruptcy Related Information[/u] [/b]: If you have filed for bankruptcy [u]and[/u] an automatic stay of bankruptcy is E
E
[b] [u]Information for Individual Debtors Filing a Joint Federal Income Tax Return[/u] [/b]: TOP automatically refers debts to the E
E
If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may E
E
If you call, please be sure that you have this letter available so that you can readily provide us with the identification information E
E

Sincerely, E
E
E
E
MSP Supervisor E

cc: [b] &CC_NAME [/b] E
E
Enclosures: E
Payment Summary Form E
&DUMM1 E
&DUMM1 E
&DUMM1 E

Name: [b] &HBENEFICIARY_NAME [/b] E
HIC #: [b] &HHIC_NUMBER [/b] E
Date of Incident: [b] &MSP_EFFECTIVE_DATE [/b] E
Debt Identification No.: [b] &CASE_NUMBER [/b] E
Demand Amount: [b] &DEMAND_AMOUNT [/b] E

Dear Sir/Madam: E
E
This letter follows our earlier communication in which we advised you or your client that you or your client would be required to E
E
The Medicare Secondary Payer provisions of the statute, 42 U.S.C. 1395y(b) (2), preclude Medicare from paying for a beneficiary's E
E
Medicare's regulations require that you or your client pay Medicare within 60 days of the receipt of settlement or insurance proceeds. E
E
Exercising Common Law authority and consistent with the Federal Claims Collection Act and 45 CFR 30.13, interest will be assessed on E
E
If you or your client does not repay this overpayment, Medicare has the authority to refer it to the Social Security Administration. E
E
The law requires that you or your client must repay an overpayment to Medicare unless both of the following conditions, as the E
E
(1) This overpayment was not your fault, because the information you gave us with your claim was correct and complete as far as E
E
AND E
E
(2) Paying back this money would cause financial hardship OR would be unfair for some other reason. E

If you believe that BOTH of the conditions above apply in your or your client's case, please let us know, giving a brief statement of why you or your client disagree that you or your client have received an overpayment.
For Part A and Part B services, you or your client must file an appeal within 120 days from the date of the receipt of this determination.

[b]&CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_ADDRESS3 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

If you have any questions, you may contact [b] &CONTRACTOR_NAME [/b] at [b] &CONTRACT_STATE_TOLL_FREE_NUM, or any other contact information provided to you.
Sincerely,

[b] MSP Supervisor [/b]

cc: [b] &CC_NAME [/b]

Enclosure:
Payment Summary Form

Name: [b] &HBENEFICIARY_NAME [/b]
HIC #: [b] &HHIC_NUMBER [/b]
Date of Incident: [b] &MSP_EFFECTIVE_DATE [/b]
Debt Identification No: [b] &CASE_NUMBER [/b]
Demand Amount: [b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam:

This letter follows our earlier communication in which we advised you that you would have to repay Medicare for services paid for by Medicare. The Medicare Secondary Payer provisions of the statute, 42 U.S.C. 1395y(b) (2), preclude Medicare from paying for a beneficiary's Medicare's regulations require that you pay Medicare within 60 days of your receipt of settlement or insurance proceeds. There may be an exception to this rule. Exercising Common Law authority and consistent with the Federal Claims Collection Act, interest will be assessed if this debt is not paid within 60 days. If the amount repaid for any services that appear on the enclosed payment summary is less than the amount that Medicare paid for those services, you will be responsible for the balance.

If you have any questions about this letter, you may contact [b] &CONTRACTOR_NAME [/b] at [b] &CONTRACT_STATE_TOLL_FREE_NUM, or any other contact information provided to you.
Sincerely,

MSP Supervisor

[b]&CONTRACTOR_NAME[/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

Enclosure:
Payment Summary Form
&DUMMY
Fecha: &LETTER_DT
Date : &LETTER_DT
Letter Number : &LETTER_NUMBER
Número de la carta: &LETTER_NUMBER

[b] FIRST REQUEST [/b]

CERTIFIED MAIL &CERTIFIED_MAIL_NUMBER

Medicare Overpayment
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

On &INVOICE_DATE we received your cost report for the fiscal year ending &FYE_DATE, which indicates an overpayment of &DEMAND_AMOUNT (principal plus interest) due the Medicare Program. The cost report, as filed, reflects an overpayment of &DEMAND_AMOUNT. The total of &DEMAND_AMOUNT should immediately be refunded in full. Your facility's check should include your provider number and be made payable to MEDICARE FEDERAL HIB.

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

If payment in full is not received, payments to you will be withheld until payment in full is received or an acceptable extended repayment request is received. If you have reason to believe that the withhold should not occur, you must notify us in writing within 30 days of the date of this letter. In accordance with 42 CFR 405.378 simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpaid balance of the overpayment beginning on the 31st day. Interest is calculated in 30-day periods and is assessed on the unpaid balance. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Accordingly, we request that you immediately notify us of any such filing. Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM.

We expect to hear from you shortly.

Sincerely,

&ELECTRONIC_SIGNATURE

Supervisor, Part A Overpayments
&CONTRACTOR_NAME

Enclosure: Extended Repayment Plan Request

[b] THIRD REQUEST [/b]

[b] Medicare Overpayment and Notice of Intent to Refer Debt to the Department of [b]
[b] Treasury's Debt Collection Center for Cross Servicing and Offset of Federal [b]
[b] Payments [/b]
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

On &SECOND_LETTER_DATE , we sent you a second request for an overpayment that resulted from Fiscal Year End &FYE_DATE

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment is received.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is not paid, interest will continue to accrue.

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt may be referred to the Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debt to the Department of Treasury.

The Debt Collection Center shall use various tools to collect the debt, including offset, demand letters, phone calls, referral to a collection agency, and litigation.

During the collection process, interest shall continue to accrue on the debt and you shall remain legally responsible for any amount due.

[u] For Individual Debtors Filing a Joint Federal Income Tax Return [/u]

The Treasury Offset Program automatically refers debt to the IRS for offset. Your Federal income tax refund is subject to offset for the amount of your debt.

[u] Federal Salary Offset [/u]

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become an individual.

[u] Medicaid Offset [/u]

As authorized at 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to offset your debt.

Please read the following instructions carefully to determine what action you should take to avoid referral for cross servicing/offset.

[u] Due Process [/u]

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing.

[u] Repayment [/u]

Your debt shall not be referred to the Department of Treasury if you make payment in full. The past due amount owed to the Medicare Program is:

Your check or money order for the amount due should be made payable to:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Include a copy of this letter with your payment.

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement. If you are interested, please contact your overpayment consultant.

[u] Bankruptcy [/u]

If you have filed for bankruptcy and an automatic stay is in effect, you are not subject to offset while the automatic stay is in effect.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this in writing.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved through the bankruptcy process.

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this withholding is not sufficient to satisfy your debt, we will refer your debt to the Department of Treasury.

Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM. We extend our appreciation for your cooperation.

Sincerely,

&ELECTRONIC_SIGNATURE

Supervisor, Part A Overpayments

&CONTRACTOR_NAME

Letter Number: &LETTER_NUMBER

Date: &LETTER_DT

&HPROVIDER_NAME
&HPROVIDER_ADDRESS1
&HPROVIDER_ADDRESS2
&HPROVIDER_CITY, &HPROVIDER_STATE &HPROVIDER_POSTAL_CODE

[b] SECOND REQUEST [/b]

Medicare Overpayment
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE

Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

On &DATE_OF_ORIGINAL_DEMAND_LETTER, we sent you a request for an overpayment that resulted from Fiscal Year End &F

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment is

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this with

Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM. We ex

Sincerely,

&ELECTRONIC_SIGNATURE

Supervisor, Part A Overpayments
&CONTRACTOR_NAME

[b] SECOND REQUEST [/b]

[b] Late Medicare Cost Report [/b]
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

This is our second letter to you noting that we have not received the cost report for &HPROVIDER_NAME, provider number &

Deemed Overpayment:

As neither cost report or payment for the deemed overpayment has been received from your facility, all interim and lump sum

Suspension:

[u] As your cost report has not been received timely, all payments to your facility continue to be suspended under the authority

Interest Charges:

Interest is assessed on late cost reports and late payments under Title 42 CFR 405.378(c)(1)(v):

1. Cost reports reflecting an amount due the Medicare program must include the amount owed (including interest) from the da
2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not includ
3. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settleme

Interest Computation:

The interest rate in effect at the time your cost report was due is &AR_INTEREST_RATE percent. This rate is applicable to any

Cost Report Submission:

Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together wil

&CONTRACTOR_NAME
&CR_ADDRESSEE
&CR_ADDRESS1
&CR_ADDRESS2
&CR_CITY, &CR_STATE &CR_POSTAL_CODE

As you are aware, cost reports are subject to further review. There could be additional adjustments required after completion o

As we informed you previously, if you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare fin

Termination of Medicare Provider Agreement:

Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit th

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions conc

Sincerely,

Reimbursement Technician, Provider Reimbursement
&CONTRACTOR_NAME

[b] THIRD REQUEST [/b]

[b] Late Medicare Cost Report [/b]
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

[b] Notice of Intent to Refer Unfiled Cost Report Debts to the Department of Treasury's Debt Collection Center for Cross Servic

Dear Sir/Madam,

This is our third letter to you noting that we have not received the cost report for &HPROVIDER_NAME, provider number &HPR

Deemed Overpayment:
As neither cost report or payment for the deemed overpayment has been received from your facility, all interim and lump sum

Your unfiled cost report debt to the Medicare Program is delinquent and, by this letter we are providing notice that your debt r
The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debt to the Department of

The Debt Collection Center may use various tools to collect the debt, including offset, demand letters, phone calls, referral to a
For Individual Debtors Filing a Joint Federal Income Tax Return:
The Treasury Offset program automatically refers debt to the IRS for offset. Your Federal income tax refund is subject to offse

Federal Salary Offset:
If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or becon

Medicaid Offset:
As authorized in 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to o

[b] [u] Please read the following instructions carefully to determine what action you should take to avoid referral for cross servi
Due Process:
You have the right to request an opportunity to inspect and copy records relating to the unfiled cost report debt. This request

Repayment:
Your unfiled cost report debt(s) shall not be referred to the Department of Treasury if you submit the cost report or make the p
Your check or money order for the amount due should be made payable to:

&CONTRACTOR_NAME
&CR_ADDRESSEE
&CR_ADDRESS1
&CR_ADDRESS2
&CR_CITY, &CR_STATE &CR_POSTAL_CODE

[b] Include a copy of this letter with your payment. [/b]
If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement. If you are intere

As you are aware, cost reports are subject to further review. There could be additional adjustments required after completion o
As we informed you previously, if you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare fin

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit t

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions conc
Sincerely,

Reimbursement Technician, Provider Reimbursement
&CONTRACTOR_NAME

[b] FIRST REQUEST [/b]

Claims Accounts Receivable
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

Claims adjustments were entered in our system under provider &HPROVIDER_NAME. Additional adjustments were made to the
Please return the overpaid amount to us by &LETTER_DATE_29 and no interest charge will be assessed. Make the check payal

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Until payment in full is received or an acceptable extended repayment request is received all payments due to you are being w
In accordance with 42 C.F.R. 405.378 simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpal

In addition, please note that Medicare rules require that payment be either received in our office by, &LETTER_DATE_29, or Ur
We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this

If you feel you have reason to appeal to appeal this adjustment, please refer to the original remittance advice for additional ins
If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding Medicare financial obligations will be resolv

Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM. We lo
Sincerely,

Supervisor, Part A Overpayments
&CONTRACTOR_NAME

Enclosures:
How This Overpayment Was Determined
Extended Repayment Plan Request

[b] THIRD REQUEST [/b]

[b] Medicare Overpayment and Notice of Intent to Refer Debt to the [/b]
[b] Department of Treasury's Debt Collection Center for Cross Servicing and [/b]
[b] Offset of Federal Payments [/b]

Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

On &SECOND_LETTER_DATE , we sent you a second request for an overpayment that resulted from claim(s) accounts receivable.

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is not paid in full, interest will continue to accrue.

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt will be referred to the Department of the Treasury for collection.

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debt to the Department of the Treasury for collection.

The Debt Collection Center shall use various tools to collect the debt, including offset, demand letters, phone calls, referral to a collection agency, and litigation.

During the collection process, interest shall continue to accrue on the debt and you shall remain legally responsible for any amount due.

[u] For Individual Debtors Filing a Joint Federal Income Tax Return [u]

The Treasury Offset Program automatically refers debt to the IRS for offset. Your Federal income tax refund is subject to offset.

[u] Federal Salary Offset [u]

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become an individual debtor.

[u] Medicaid Offset [u]

As authorized at 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to offset your Medicaid payments against the debt.

Please read the following instructions carefully to determine what action you should take to avoid referral for cross servicing/offset.

[u] Due Process [u]

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing.

[u] Repayment [u]

Your debt shall not be referred to the Department of Treasury if you make payment in full. The past due amount owed to the Medicare Program is:

Your check or money order for the amount due should be made payable to:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Include a copy of this letter with your payment.

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement. If you are interested in such an agreement, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM.

[u] Bankruptcy [u]

If you have filed for bankruptcy and an automatic stay is in effect, you are not subject to offset while the automatic stay is in effect.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this in writing.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved through the bankruptcy process.

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this withholding is not sufficient to satisfy the debt, we will refer the debt to the Department of the Treasury for collection.

Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM. We will be glad to assist you.

Sincerely,

Supervisor, Part A Overpayments
&CONTRACTOR_NAME

[b] SECOND REQUEST [b]

Medicare Overpayment
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

On &DATE_OF_ORIGINAL_DEMAND_LETTER, we sent you a request for an overpayment that resulted from claim(s) accounts receivable.

PLEASE MAIL TO:

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

Your payments have been withheld and are being applied against the overpayment. This withhold will continue until payment in full is received.

In accordance with 42 CFR 405.378, interest is being assessed on the amount due the Medicare Program. If the overpayment is not paid in full, interest will continue to accrue.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this in writing.

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved through the bankruptcy process.

If applicable, we have also initiated a request that your Federal share of Title XIX (Medicaid) payments be withheld. If this with
Should you have any questions, please contact your overpayment consultant at &CONTRACT_STATE_TOLL_FREE_NUM. We lo
Sincerely,

- Supervisor, Part A Overpayments
- &CONTRACTOR_NAME
- &CONTRACT_STATE_TOLL_FREE_NUM
- &CONTRACTOR_NAME
- &CHECK_ADDRESSEE
- &CHECK_ADDRESSE1
- &CHECK_ADDRESS2
- &CHECK_CITY
- &CHECK_STATE
- &CHECK_POSTAL_CODE
- &ERS_ADDRESSEE
- &ERS_ADDRESSE1
- &ERS_ADDRESS2
- &ERS_CITY
- &ERS_STATE
- &ERS_POSTAL_CODE
- Automated Adjustment
- Admission Denial - Technical Denial (Pro Review Code - A)
- Admission Denial - No Payment (Medical Denial) (Pro Review Code - A)
- Admission Reversal - Hard Copy Adjustment
- Automobile
- Admission Denial - Payable Per Waiver
- Same Day Transfer
- CWF Corrupted Bene Correction
- HHPPS Final Not Received
- Black Lung
- Cost Outlier Approved
- Credit Balance Accounts
- Change Charge
- Covered Days Changes (Pro Review Code - B)
- Coverage
- Cost Outlier - No Payment (Pro Review Code - E)
- Cost Outlier Partial Approved
- Claim Reconsideration
- Adj. Due To Cert. Review
- Cost Outlier Denial - Payable Per Waiver
- Day Outlier Approved
- Disability
- Diagnosis Changes (Pro Review Code - C)
- Discharge Destination Code Changes (Pro Review Code - C)
- Adj. Due To Dave Review
- Duplicate
- DRG Change And Day Outlier Denial (Pro Review Code - G)
- DRG Change And Cost Outlier Denial (Pro Review Code - H)
- DRG And Beneficiary Liability Change (Pro Review Code - I)
- Day Outlier Denial - No Payment (Pro Review Code - D)
- Diagnosis And Procedure Changes (Pro Review Code - C)
- Discharge Status Change
- Change In Dates Of Service
- DRG Validation (Pro Review Code - C)
- Day Outlier Denial - Payable Per Waiver
- ESRD Adjustment Fix To Correct Original Claims
- ESRD
- Beneficiary Liability Change (Pro Review Code - F)
- HHPPS Final Claim
- Full Denial (Pro Review Code - A)
- Provider Canceled Episode
- Fiscal Intermediary Canceled Episode
- Full Reversal (Pro Review Code - N)
- Full Denial - Technical Denial (Pro Review Code - A)
- Ban On Payment
- Home Health 485/486 Postpayment Audits
- Home Health Covered Compliance Reviews
- HMO Disenrollment
- Other
- SNF Recons
- HMO Pay
- PPS Interim Bill
- Non-Billable Revenue Codes Invalid Revenue Codes
- Inpatient Or Blood Deductible
- Certs
- Probes
- Deemed Admission Change In Days (Pro Review Code - J)
- Deemed Admission Change In Days (Pro Review Code - J)
- Deemed Admission/Diagnosis Code Change (Pro Review Code - K)
- Appeals Outpatient
- Deemed Admission/Procedure Code Change (Pro Review Code - K)
- Deemed Admission/Day Outlier Denial (Pro Review Code - L)
- Liability
- Sanctioned Upin
- Length Of Stay Denial - No Payment
- Length Of Stay Denial - Payable Per Waiver
- Mass Adjustment - CMS Mandated
- Deemed Admission/Cost Outlier Denial (Pro Review Code - M)
- ALJ
- Mass Adjustment - Other
- MR Post Pay Denials
- HHPPS No Final Claim
- Fair Hearing
- Procedure Codes Changed, Denied, Or Added (Pro Review Code - R)
- Outpatient Ancillary Services Denied Or Approved (O)
- Adjustments For OIG Transfer Project, July/August 2002
- Part B Review
- Day Outlier Approved
- Outpatient Redetermination
- Other Change
- Procedure Changes (Pro Review Code - C)

Procedural Denial - No Payment
Plan Transfer
Public Health Service (Phs) MSP Value Code 16
Program Integrity
Provider Number Change
Discharge Status Change (Pro Review Code - P)
Previous Adjustment Modified (Modifies The Pros Last Action) (Pro Review Code - O)
Admission Denial And DRG Change (Pro Review Code - T)
Procedural Denial - Payable Per Waiver
Procedure Codes (HCPCS) Changed/Deleted/Added (Pro Review Code - R)
Ancillary Services Denied Or Approved (Pro Review Code - Q)
Update Timely Filing
HCPC Added/Deleted/Changed With Ancillary Change (Pro Review Code - S)
Complete Reversal Of Previous Adjustment (Pro Review Code - N)
RAC Identified
Partial Reversal Of Previous Adjustment (Pro Review Code - O)
Change Patient Status
Increase In Covered Services
Same Benefit Period
Change In Professional Comp Amt
Seven Day Readmission Denial
Pro-Related Utilization Adj.
Scramble HIC
Services Not Provided/Billed In Error
Change In Dates Of Service
Inpatient/Outpatient Claim Service Dates
Change Due To Part A & B
Reopen
Qualified Independent Contractor
Special Project - Provider Initiated
Change/Add Occurrence Span Code
Adjustment To Spin Off Claim
Seven Day Readmission Denial - Payable Per Waiver
Special Project -Intermediary Initiated
Change From Untimely To Timely
Medicare Secondary To Medicare Primary
Transfer Denial - No Payment
Telephone Review Decision
Change/Add Diagnosis (Ncd)
Transfer Denial - Payable Per Waiver
Affects Beneficiary Utilization
Change HCPCS Code
Veteran's Administration
Mod Add/Remove (Inc Black Lung)
Corrected CPT Code
Duplicate
Billed In Error
Services Not Rendered
MSP Group Health Plan Insurance
Patient Enroll HMO
MSP No Fault Insurance
MSP Liability
Medical Necessity
Insufficient Documentation
Not Our Patient (S)
Other
Corrected Date Of Service
Veterans Administration
MSP Workers Comp
Worker's Compensation
Working Elderly
Change Dates Of Service
Decrease In Charges
Pacemaker Denial - No Data
Pacemaker Denial - With Errors
Pacemaker Reversal To Denial
Pacemaker Reversal To Denial And Not Going To Pay
Change/Add Modifiers
OIG PPS Transfer Recovery
OIG Duplicate Payment Report
Debit Adjustment For Provider And Intermediary - Initial Bill Processed To CWF
Increase In Charges

[b] FIRST DEMAND LETTER [/b]

CERTIFIED MAIL &CERTIFIED_MAIL_NUMBER

[b] Late Medicare Cost Report [/b]
Provider Name: &HPROVIDER_NAME
Provider Number: &HPROVIDER_NUMBER
Fiscal Year End: &FYE_DATE
Taxpayer Identification Number: &DEBTOR_EIN
Invoice Number: &HINVOICE_NUMBER

Dear Sir/Madam,

We have not received the cost report for &HPROVIDER_NAME, provider number &HPROVIDER_NUMBER for the period ending

Deemed Overpayment: Title 42 CFR 405.378 (c) (1) (v)

As a cost report has not been received from your facility, all interim and lump sum payments made for the fiscal period noted a

If full payment is not received or arrangements made for an extended repayment plan, we will take all action(s) necessary to r

Suspension:

As your cost report has not been received timely, all payments to your facility have now been suspended under the authority of

Interest Charges:

Interest is assessed on late cost reports and late payments under Title 42 CFR 405.378(c)(1)(v):

1. Cost reports reflecting an amount due the Medicare program must include the amount owed (including interest) from the da
2. If a late cost report reflects that there is an amount due Medicare and the full amount owed (including interest) is not includ
3. Additionally, when it is determined that an additional overpayment exists on a late filed cost report, through interim settleme

Interest Computation:
The interest rate in effect at the time your cost report was due is &AR_INTEREST_RATE percent. This rate is applicable to any

Cost Report Submission:
Please attend to this matter immediately by mailing a copy of this letter together with: (1) A completed cost report together with

&CONTRACTOR_NAME
&CR_ADDRESSEE
&CR_ADDRESS1
&CR_ADDRESS2
&CR_CITY, &CR_STATE &CR_POSTAL_CODE

As you are aware, cost reports are subject to further review. There could be additional adjustments required after completion of

Medicaid Offset:
If this matter is not resolved within fifteen (15) days from the date of this letter, CMS may instruct the Medicaid State Agency to

Termination of Medicare Provider Agreement:
Please be advised that under Title XVIII, Section 1866(b)(2)(A) and (C) of the Social Security Act, continued failure to submit the

If you have submitted a cost report and any payment due Medicare please disregard this letter. If you have any questions concerning

Sincerely,

Reimbursement Technician, Provider Reimbursement
&CONTRACTOR_NAME

Enclosure: Extended Repayment Plan Request

&LINVOICE_NUMBER
&LREASON_PARAGRAPH
&LCLAIM_NUMBER
&LBENEFICIARY_NAME
&LHIC_NUMBER
&LDATE_OF_SERVICE_FROM
&LDATE_OF_SERVICE_TO
&LORGNL_CLM_AMT
&LINVOICE_AMOUNT
&LPAID_DATE
&LPROVIDER_NUMBER
Letter Number: &LETTER_NUMBER
Número de la carta: &LETTER_NUMBER
Date: &LETTER_DT
Fecha: &LETTER_DT

&HBENEFICIARY_NAME
&HBENEFICIARY_NAME
&HBENEFICIARY_ADDRESS1
&HBENEFICIARY_ADDRESS1
&HBENEFICIARY_ADDRESS2
&HBENEFICIARY_ADDRESS2
&HBENEFICIARY_CITY, &HBENEFICIARY_STATE &HBENEFICIARY_POSTAL_CODE
&HBENEFICIARY_CITY, &HBENEFICIARY_STATE &HBENEFICIARY_POSTAL_CODE

Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

Dear Sir/Madam,

We appreciate your recent inquiry regarding Medicare payment that you believe was paid to you in error. Our analysis found that

[b] Why you are responsible: [/b]

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment.
(Applicable authorities: Section 1870(b) of the Social Security Act; subsections 405.350 - 405.359 of Title 42, subsections 404.501 - 404.509)

[b] What you should do: [/b]

Please return the overpaid amount to us by &LETTER_DATE_29 and no interest charge will be assessed. Make the check payable to

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

[b] If you do not refund in 30 days: [/b]

In accordance with 42 CFR 405.378 simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpaid amount

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this

If payment in full is not received by, &LETTER_DATE_40, payments to you will be withheld until payment in full is received or a

[b] If you wish to appeal this decision: [/b]

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of

&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

[b] If you have filed a bankruptcy petition: [/b]

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved

Unidad de Recuperación

Enclosure:

Adjunto:

Cómo este sobrepago fue determinado.
How This Overpayment Was Determined

Overpayment Amount: &HINVOICE_AMOUNT
Cantidad pagada en exceso: &HINVOICE_AMOUNT
Cantidad adeudada: &DEMAND_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Número de Seguro Médico (HIC): &HHIC_NUMBER
Health Insurance Claim Number: &HHIC_NUMBER

Estimado(a) Señor/Señora:
Dear Sir/Madam:

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the letter. Recientemente le enviamos una carta solicitándole la devolución de un pago en exceso. Adjunto encontrará una copia de la carta.

Si usted ha enviado el pago, le agradecemos el mismo y le pedimos ignore esta carta. If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact us. Si usted tiene alguna pregunta al respecto, favor de comunicarse con nosotros.

Sincerely,
Sinceramente,

Medicare Parte B
Medicare Part B
Recovery Unit
Unidad de Recuperación

Adjunto:

Enclosure:

Previous Demand Packet
Correspondencia Inicial
Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

Dear Sir/Madam,

We previously sent you a letter requesting that you refund an overpayment made to you. Enclosed you will find a copy of the letter. As stated in our initial letter, offset of the overpayment amount, plus interest, will be made against any pending and future assessments.

If you have already sent payment, or our letters have crossed in the mail, we thank you and ask that you please disregard this letter.

If you have any questions regarding this matter, please contact &CONTRACTOR_NAME at &CONTRACT_STATE_TOLL_FREE_NUMBER.

Sincerely,
Sinceramente,

Medicare Part B
Recovery Unit
Enclosure:
Previous Demand Packet
Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

Dear Sir/Madam,

This is to let you know that you have received a Medicare payment in error which has resulted in an overpayment to you of &HEALTHCARE_PAYMENT_AMOUNT.

[b] Why you are responsible: [/b]

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. (Applicable authorities: Section 1870(b) of the Social Security Act; subsections 405.350 - 405.359 of Title 42, subsections 404.500 - 404.509 of Title 42.)

[b] What you should do: [/b]

Please return the overpaid amount to us by &LETTER_DATE_29 and no interest charge will be assessed. Make the check payable to &CONTRACTOR_NAME.

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

[b] If you do not refund in 30 days: [/b]

In accordance with 42 CFR 405.378 simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpaid amount.

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this in writing.

If payment in full is not received by &LETTER_DATE_40, payments to you will be withheld until payment in full is received or a settlement is reached.

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of the agency that made the decision.

&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

[b] If you have filed a bankruptcy petition: [b]

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved.

Should you have any questions please do not hesitate to contact &CONTRACTOR_NAME at &CONTRACT_STATE_TOLL_FREE_NUMBER.

If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.

Sincerely,

Medicare Part B
Recovery Unit

Enclosures:
How This Overpayment Was Determined
Documentation Supporting A Request For Extended Repayment Plan

Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

[b]Notice of Intent to Refer Debt to the Department of Treasury's Debt Collection Center for Cross Servicing and Offset of Federal Debts

Dear Sir/Madam,

On &DATE_OF_ORIGINAL_DEMAND_LETTER we sent a letter requesting that you refund an overpayment made to you in the amount of &OVERPAYMENT_AMOUNT.

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt may be referred to the Department of Treasury for collection.

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debts to the Department of Treasury for collection.

The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a collection agency, and litigation.

During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount due.

[u] For Individual Debtors Filing a Joint Federal Income Tax Return [u]

The Treasury Offset Program automatically refers debts to the IRS for offset. Your Federal income tax refund is subject to offset for Federal debts.

[u]Federal Salary Offset[u]

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become an individual.

[u]Medicaid Offset[u]

As authorized at 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to offset your Medicaid benefits for Federal debts.

Please read the following instructions carefully to determine what action you may take to avoid referral for cross servicing/offset of Federal debts.

[u]Due Process[u]

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the Debt Collection Center.

[u]Repayment[u]

Your debt will not be referred to the Department of Treasury if you make payment in full. The past due amount of &DEMAND_AMOUNT must be paid in full.

Your check or money order for the amount due should be made payable to Medicare Part B and send it with a copy of this letter to the Debt Collection Center.

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement. If you are interested in an extended repayment agreement, please contact the Debt Collection Center.

[u]Bankruptcy[u]

If you have filed bankruptcy and an automatic stay is in effect, you are not subject to offset while the automatic stay is in effect. You must notify the Debt Collection Center of any change in your bankruptcy status.

If you have questions concerning this debt, please contact &CONTRACTOR_NAME at &CONTRACT_STATE_TOLL_FREE_NUMBER.

Sincerely,

&ELECTRONIC_SIGNATURE

Medicare Part B
Recovery Unit

Enclosure:
Previous Demand Packet
Overpayment Amount: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Provider Number: &HPROVIDER_NUMBER

Dear Sir/Madam,

We have received your check in the amount of &INVOICE_RECEIPT_AMOUNT. We thank you for bringing this overpayment to our attention.

[b] Why you are responsible: [b]

You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment. (Applicable authorities: Section 1870(b) of the Social Security Act; subsections 405.350 - 405.359 of Title 42, subsections 404.501 - 404.509 of Title 42)

Please return the overpaid amount to us by &LETTER_DATE_29 and no interest charge will be assessed. Make the check payable to Medicare Part B.

&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

[b] If you do not refund in 30 days: [b]

In accordance with 42 CFR 405.378 simple interest at the rate of &AR_INTEREST_RATE percent will be charged on the unpaid

We request that you refund this amount in full. If you are unable to make refund of the entire amount at this time, advise this

If payment in full is not received by, &LETTER_DATE_40, payments to you will be withheld until payment in full is received or a

[b] If you wish to appeal this decision: [b]

If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent

&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

[b] If you have filed a bankruptcy petition: [b]

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved

Should you have any questions please do not hesitate to contact &CONTRACTOR_NAME at &CONTRACT_STATE_TOLL_FREE_N

If we can assist you further in the resolution of this matter, we shall be glad to do so. We expect to hear from you shortly.

Sincerely,

Medicare Part B
Recovery Unit

Enclosures:
How This Overpayment Was Determined
Documentation Supporting A Request For Extended Repayment Plan

Overpayment Amount: &HINVOICE_AMOUNT
Cantidad pagada en exceso: &HINVOICE_AMOUNT
Outstanding Balance: &DEMAND_AMOUNT
Cantidad adeudada: &DEMAND_AMOUNT
Health Insurance Claim Number: &HHIC_NUMBER
Número de Seguro Médico (HIC): &HHIC_NUMBER

Dear Sir/Madam:
Estimado(a) Señor/Señora:

We have received your check in the amount of &INVOICE_RECEIPT_AMOUNT. We thank you for bringing this overpayment to

Favor enviar un cheque o giro postal a nombre de Medicare por la cantidad de &DEMAND_AMOUNT en o antes del día &LETTER_DATE_29
Please send a check or money order made payable to Medicare in the amount of &DEMAND_AMOUNT, by &LETTER_DATE_29

&CONTRACTOR_NAME
&CONTRACTOR_NAME
&CHECK_ADDRESS1
&CHECK_ADDRESS1
&CHECK_ADDRESS2
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

If you are unable to refund this amount in one payment, you may do so in regular installments. If you prefer to repay this over
Si usted no puede devolver esta cantidad en un solo pago, puede hacerlo a plazos. Si usted decide pagar la cantidad adeudada:

If other Medicare benefits become payable to you and you have not refunded the overpayment in full, or established a payment
Si otros beneficios de Medicare son pagaderos a usted, y usted no ha reembolsado la cantidad adeudada en su totalidad, o n

If you do not repay this overpayment, it may be referred to the Social Security Administration for further recovery action which
Si usted no devuelve la cantidad adeudada, la misma será referida a la Administración del Seguro Social (SSA), siglas en inglés,

Si tiene un plan de seguro médico privado para complementar los beneficios de Medicare, usted puede recobrar la cantidad ad
If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this over

[b] If you wish to appeal this decision: [b]
[b] Si usted desea apelar esta decisión: [b]

Si no está de acuerdo con esta decisión, usted puede apelar. Una apelación es una revisión llevada a cabo por un personal in
If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent

&CONTRACTOR_NAME
&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

La solicitud de un proceso de reconsideración o una audiencia no alterará la solicitud de la recuperación del pago en exceso ha

Please understand that a request for redetermination will not alter the overpayment request until a final decision has been determined.

Si este pago ya ha sido enviado a nuestra oficina, favor proveer el número de cheque y devolver la página adjunta.
If this payment has already been refunded to our office, please supply us with the check number and return the attached page.

Le agradecemos de antemano su pronta atención a esta asunto. Si usted tiene alguna pregunta con relación a este pago en especial.
Thank you in advance for your prompt attention to this matter. If you have questions regarding this overpayment, please call.

Sinceramente,
Sincerely,

Medicare Part B
Medicare Parte B
Recovery Unit
Unidad de Recuperación

Adjunto:
Enclosure:
Como se Determinó el Pago en Exceso
How This Overpayment Was Determined
Letter Number: &LETTER_NUMBER
Número de la carta: &LETTER_NUMBER
Fecha: &LETTER_DT
Date: &LETTER_DT

Al beneficiario de &HBENEFICIARY_NAME
Estate of &HBENEFICIARY_NAME
&HBENEFICIARY_ADDRESS1
&HBENEFICIARY_ADDRESS1
&HBENEFICIARY_ADDRESS2
&HBENEFICIARY_ADDRESS2
&HBENEFICIARY_CITY, &HBENEFICIARY_STATE &HBENEFICIARY_POSTAL_CODE
&HBENEFICIARY_CITY, &HBENEFICIARY_STATE &HBENEFICIARY_POSTAL_CODE

&CONTRACTOR_NAME
&ERP_ADDRESSEE
&ERP_ADDRESS1
&ERP_ADDRESS2
&ERP_CITY
&ERP_STATE
&ERP_POSTAL_CODE

La reclamación fue pagada con la fecha(s) incorrecta de servicio. Por lo tanto, el pago fue efectuado por error.
The claim was paid with incorrect date(s) of service. Therefore, payment was made in error.
The claim was paid with incorrect date(s) of service. Therefore, payment was made in error.
La reclamación fue sometida o procesada con la información incorrecta concerniente al código de procedimiento (CPT), siglas eS
The claim was either submitted or processed with incorrect information concerning the procedure (CPT) code. Therefore, payment was made to you in error.
La reclamación original fue pagada en base a la documentación recibida respaldando el pago al momento de ser procesada. CoS
The original claim was paid based on documentation received supporting the payment at the time of processing. With new information received, the amount paid was incorrect. Therefore, payment was made to you in error.
La reclamación fue pagada por un día de servicio en el que el cliente estaba suscrito a una Organización de Cuido AdministradoS
The claim was paid for a date of service when the patient was enrolled in an Health Maintenance Organization (HMO). Therefore, payment was made to you in error.
Hemos sido informados que en la reclamación pagada el paciente estaba incorrecto. Por lo tanto, el pago fue efectuado por errorS
We were informed that on the paid claim the patient was incorrect. Therefore, payment was made to you in error.
We were informed that on the paid claim the patient was incorrect. Therefore, payment was made to you in error.
La reclamación fue pagada con un calificativo incorrecto dentro del código de procedimiento. Por lo tanto, el pago fue efectuadoS
The claim was paid with an incorrect modifier within the procedure code. Therefore, payment was made to you in error.
The claim was paid with an incorrect modifier within the procedure code. Therefore, payment was made to you in error.
Nuestros registros indican que la reclamación fue pagada con una cantidad incorrecta. Esto resultó en un pago erróneo hacia uS
Our records indicate that the claim was paid with an incorrect allowance. This resulted in an inaccurate payment made to you.
Our records indicate that the claim was paid with an incorrect allowance. This resulted in an inaccurate payment made to you.
Bajo la Política de Medicare, no se pueden hacer pagos por servicios médicos prestados después de la fecha de defunción. NueS
Under Medicare Policy, payments can not be made for services performed beyond the date of death. Our records indicate that the billed date of service is after the beneficiary's date of death. Therefore, payment was made in error.
Your claim was selected for the Comprehensive Error Rate Testing (CERT) process. Based on this CERT audit, a payment was made in error for one of the following: 1) You did not respond to the CERT request for records, or responded incorrectly.
Su reclamación fue seleccionada para el proceso de la Prueba Comprensiva de Estimación de Errores (CERT), siglas en inglés. ES
Your claim was selected for the Comprehensive Error Rate Testing (CERT) process. Based on this CERT audit, a payment was made in error for one of the following: 1) You did not respond to the CERT request for records, or responded incorrectly.
La reclamación fue preparada incorrectamente ocasionando una duplicación en el pago.
The claim was incorrectly prepared causing a duplicate payment to be made to you.
The claim was incorrectly prepared causing a duplicate payment to be made to you.
When the claim processed, the patient deductible was not properly assessed. Therefore, payment was made to you in error.
Cuando se procesó la reclamación, el deducible no fue calculado correctamente. Por lo tanto, el pago fue efectuado por error. S
When the claim processed, the patient deductible was not properly assessed. Therefore, payment was made to you in error.
Our records indicate that the incorrect year of service has been reported. Therefore, the payment was made to you in error.
Nuestros registros indican que se reportó el año incorrecto por servicios. Por lo tanto, el pago fue efectuado por error. S
Our records indicate that the incorrect year of service has been reported. Therefore, the payment was made to you in error.
Our records indicate that one or more claims included in a previous HPSA incentive payment has/have been adjusted and resulted in an overpayment of the incentive payment.
Our records indicate that on the date(s) services were provided, the address where the services were performed was not in a HPSA designated area. Therefore, the HPSA incentive payment was made in error.
De acuerdo con la política de Medicare, el cargo emitido por cirugía incluye una cubierta para visitas dentro del periodo de recuperación.
According to Medicare policy, the fee issued for surgery includes coverage for any visits rendered within the aftercare period.

Basado en la Política de Medicare, servicios dentro del periodo de Cuido en el Hogar (HH), siglas en inglés, son sujetos a una facturación

&CHECK_ADDRESS2
&CHECK_ADDRESS2
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE
&CHECK_CITY, &CHECK_STATE &CHECK_POSTAL_CODE

If you are unable to refund this amount in one payment, you may do so in regular installments. If you prefer to repay this over
Si usted no puede devolver esta cantidad en un solo pago, usted puede hacerlo a plazos. Si usted decide pagar la cantidad adeudada

Si otros beneficios de Medicare son pagaderos a usted, y usted no ha reembolsado la cantidad adeudada en su totalidad, o r
If other Medicare benefits become payable to you and you have not refunded the overpayment in full, or established a payment

Si usted no devuelve la cantidad adeudada, la misma será referida a la Administración del Seguro Social (SSA), siglas en inglés,
If you do not repay this overpayment, it may be referred to the Social Security Administration for further recovery action which

If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this over
Si tiene un plan de seguro médico privado para suplementar los beneficios de Medicare, usted puede recobrar la cantidad adeudada

[b]If you wish to appeal this decision:[/b]
[b]Si usted desea apelar esta decisión:[/b]

Si no está de acuerdo con esta decisión, usted puede apelar. Una apelación es una revisión llevada a cabo por un personal independiente
If you disagree with this overpayment decision, you may file an appeal. An appeal is a review performed by people independent of

&CONTRACTOR_NAME
&CONTRACTOR_NAME
&REVIEW_ADDRESS1
&REVIEW_ADDRESS1
&REVIEW_ADDRESS2
&REVIEW_ADDRESS2
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE
&REVIEW_CITY, &REVIEW_STATE &REVIEW_POSTAL_CODE

Please understand that a request for redetermination will not alter the overpayment request until a final decision has been determined
La solicitud de un proceso de reconsideración o una audiencia no alterará la solicitud de la recuperación del pago en exceso hasta que se determine

If this payment has already been refunded to our office, please supply us with the check number and return the attached page
Si este pago ya ha sido enviado a nuestra oficina, favor proveer el número de cheque y devolver la página adjunta.

Thank you in advance for your prompt attention to this matter. If you have questions regarding this overpayment, please call
Le agradecemos por adelantado su pronta atención a este asunto. Si usted tiene alguna pregunta con relación a este pago en exceso, llame

Sincerely,
Sinceramente,

Medicare Parte B
Medicare Part B
Recovery Unit
Unidad de Recuperación

Adjunto:
Enclosure:
Como se Determinó el Pago en Exceso
How This Overpayment Was Determined

&LINVOICE_NUMBER
&LINVOICE_NUMBER
&LREASON_PARAGRAPH
&LREASON_PARAGRAPH
&LCLAIM_NUMBER
&LCLAIM_NUMBER
&LHIC_NUMBER
&LHIC_NUMBER
&LDATE_OF_SERVICE_FROM
&LDATE_OF_SERVICE_FROM
&LDATE_OF_SERVICE_TO
&LDATE_OF_SERVICE_TO
&LINVOICE_AMOUNT
&LINVOICE_AMOUNT
&LPAID_DATE
&LPAID_DATE
&LPROVIDER_NAME
&LPROVIDER_NAME
&LINVOICE_NUMBER
&LCLAIM_NUMBER
&LBENEFICIARY_NAME
&LHIC_NUMBER
&LDATE_OF_SERVICE_FROM
&LDATE_OF_SERVICE_TO
&LINVOICE_AMOUNT
&LPAID_DATE
&LPROVIDER_NUMBER

&LCLAIM_NUMBER

[b] VI. Whom should I contact if I have questions about this letter? [/b]

This office is the Medicare contractor responsible for handling your case. If you have any questions about this letter, or questions about Medicare's recovery rights in general, please contact [b] &CONTRACTOR_NAME [/b] at [b] &CONT

Sincerely,

MSP Supervisor
[b] &CONTRACTOR_NAME [/b]
[b] &MSP_ADDRESS1 [/b]
[b] &MSP_ADDRESS2 [/b]
[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

cc: &CC_NAME

Enclosure:
Payment Summary Form
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

[b]PLEASE REFRAIN FROM MAKING PAYMENT AT THIS TIME[/b]

Date: &LETTER_DT

[b] &ADDRESSEE_NAME [/b]
[b] &ADDRESSEE_ADDRESS1 [/b]
[b] &ADDRESSEE_CITY, &ADDRESSEE_STATE, &ADDRESSEE_POSTAL_CODE [/b]

Name of Beneficiary: [b] &HBENEFICIARY_NAME [/b]
HIC #: [b] &HHIC_NUMBER [/b]
Date of Incident: [b] &CASE_EFFECTIVE_DATE [/b]

Dear Sir/Madam:

[b] [u] Please note that if we know that you have an attorney or other individual representing you in this matter, we are sendin

This communication follows a previous letter notifying you/your attorney of Medicare's priority right of recovery as defined unde

[b]However, we request that you refrain from sending any monies to Medicare prior to submission of settlement/resolution info

Currently, Medicare has paid [b]&DEMAND_AMOUNT[/b] in conditional payments related to this workers' compensation claim.

[b]Please be advised that we are still investigating this matter to obtain any other outstanding Medicare conditional payments.

If the case has been resolved, please furnish our office with a copy of:

The settlement/resolution agreement from the workers' compensation carrier showing the total amount of the settlement, sign

Your closing statement reflecting the actual amount of the attorney's fees and costs. We request that you also include a statem

Thank you for your assistance and cooperation in this matter. If you have any questions regarding this matter, please contact r

Sincerely,

&ELECTRONIC_SIGNATURE

MSP Supervisor
[b] &CONTRACTOR_NAME [/b]

Enclosure: Payment Summary Form

Name: [b] &HBENEFICIARY_NAME [/b]
HIC #: [b] &HHIC_NUMBER [/b]
Date of Incident: [b] &MSP_EFFECTIVE_DATE [/b]
Debt Identification No.: [b] &CASE_NUMBER [/b]
Demand Amount: [b] &DEMAND_AMOUNT [/b]

Dear Sir/Madam:

This is a formal demand for repayment of mistaken Medicare payments. Information we have received suggest that these serv

A summary of claims paid which appear to be related to the above incident is enclosed. You are requested to provide (within 6

Repayment of the amount identified as a mistaken payment or an amount payable under your coverage (as primary payer). PI

An explanation of why this case is not subject to the cited MSP (Medicare Secondary Payer) provision or other reason for not m

You are hereby advised of the following:

The Centers for Medicare & Medicaid Services has a statutory right of recovery. An action may be brought by the United States, to recover payments mistakenly made by Medicare against any entity required

For further reference to the Medicare program's right of recovery and potential penalties for non-compliance, please see 42 U.S.E

[b]NOTICE: [/b] Failure to respond to this request will be taken as evidence of non-compliance with our primary responsibility.

Please refund [b] &DEMAND_AMOUNT [/b], payable to [b] &CONTRACTOR_NAME [/b] to the following address:

[b] &MSP_CITY, &MSP_STATE &MSP_POSTAL_CODE [/b]

If you have any questions about this letter, you may contact [b]&CONTRACTOR_NAME[/b] at [b]&CONTRACT_STATE_TOLL_FEE

Sincerely,

MSP Supervisor

Enclosure:
Payment Summary Form

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ought recovery from liability insurance. Federal law requires Medicare beneficiaries who obtain a liability insurance recovery to repay the United States the amount the Medicare program paid for conditions related to that recovery. This r
settlement, judgment, or award.

? C.F.R. 411.37. To make a deduction for your procurement costs, you need to provide: 1) a copy of the settlement agreement, judgment, or award; and 2) complete information concerning your attorney fees and other expenses.

Administrator. If, in the future, you receive additional funds under this settlement, you must notify the Medicare program. The Medicare program will then determine whether you must repay any additional funds. Additionally, you must
d, you must notify the Medicare program. The Medicare program will then determine whether you must repay any additional funds.

le to [b] &CONTRACTOR_NAME, &CONTRACTOR_ADDRESS1, &CONTRACTOR_ADDRESS2, &CONTRACTOR_CITY, &CONTRACTOR_STATE, &CONTRACTOR_POSTAL_CODE [/b]. Payment does not affect your right to appeal or request a
F.R. 411.24(m). Interest will continue to accrue until the debt is paid, whether or not a waiver of recovery request or appeal is pending.

would otherwise pay you. Also, please be aware that Medicare must refer delinquent debts to the Department of the Treasury for offset against Federal payments that may be due or for other appropriate collection actions.

sd to reimburse the Medicare program if you alleged certain injuries and the payment took into account those injuries.

aptured - even though the manufacturer has not admitted liability for such illnesses or injuries and/or a causal linkage has not been established. Consequently, Medicare includes Medicare reimbursed items and services related to such illn
Information that you can provide which will allow us to determine what you claimed and recovered includes: the settlement, judgment, or award; the legal complaint; correspondence between the parties regarding alleged injuries and/o
ng paragraph within thirty (30) days of the date of this letter, Medicare will examine the information to determine if it warrants a change in the amount you must refund to Medicare. After examining the information, Medicare will issue a
determining the amount you owe.

complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment,

easons. Your request should be sent to [b] &CONTRACTOR_NAME, &CONTRACTOR_ADDRESS1, &CONTRACTOR_ADDRESS2, &CONTRACTOR_CITY, &CONTRACTOR_STATE, &CONTRACTOR_POSTAL_CODE[/b]. You will be sent a form
ys from the date of your receipt of this determination. For Part B services, you must file an appeal within six (6) months of the date of this determination. However, we recommend that you file appeals of Part A and Part B claims within
wyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

group health plan has acknowledged that it was the proper primary payer and has reported that it made primary payment to you. We are unable to locate any records showing that you subsequently refunded Medicare's payment or submit a valid documented defense within 30 days, we will collect against future Medicare payments to you. If we do not receive payment from you by check or through recoupment from future Medicare payments to you, we will refer the debt of this letter and is charged for each 30-day period that payment is delayed. (Periods of less than 30 days are treated as a full 30-day period. The current rate of interest is [b]&AR_INTEREST_RATE[/b]%. Medicare charges interest on "without fault" with respect to the debt.

pending and future claims. If you do not repay the debt within 30 days, we will apply your payment, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act of 1990, your rebuttal information should include proof that you already repaid Medicare, or proof that the sum the group health plan asserts it paid you is incorrect. You may include with this statement any evidence you believe is pertinent to your request.

our determination. However, recoupment will not be delayed beyond the date stated in this notice while we review your rebuttal statement. If put into effect, the recoupment will remain in effect until the earliest of the following: (1) the date you repay the debt, or (2) the date you submit proof that you already repaid Medicare, or (3) the date you submit proof that the sum the group health plan asserts it paid you is incorrect. If you do not repay the debt within 30 days, we will apply your payment, and amounts we recoup, first to accrued interest and then to principal. Also, in accordance with the Debt Collection Improvement Act of 1990, your rebuttal information should include proof that you already repaid Medicare, or proof that the sum the group health plan asserts it paid you is incorrect. You may include with this statement any evidence you believe is pertinent to your request.

overpayment of &HINVOICE_AMOUNT for this fiscal year. The Provider Reimbursement Manual (PRM) Part 1, Chapter 24, Section 2409.A(2) states that when a cost report is filed indicating an overpayment, a full refund should accompany

notify &CONTRACTOR_NAME. We will review your documentation, but will not delay recoupment. This is not an appeal of the overpayment determination. The appeal process is detailed in the NPR. In addition, in accordance with 42 CFR 401.101-103, interest will be assessed for each full 30-day period that payment is not made in full. Thus, if payment is received 31 days from the date of final determination, one 30-day period of interest will be charged and will continue to be assessed for full 30-day periods thereafter. Please notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice so as to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy,

d with insufficient documentaiton. 2) Your documentation did not support the level of service billed. The claim has been adjusted to reflect the level of service determined by the CERT contractor.

ent was made to you in error.

Therefore, payment was made to you in error.



support the claim. Therefore, payment was made to you in error.

ation that was requested to support the claim. Therefore, payment was made to you in error.

ans that met this criteria. Therefore, payment was made to you in error.

Information answers questions you may have.

Provider or supplier when the provider or supplier failed to identify and bill third party payers that are primary payers to Medicare. There are two exceptions to this rule: (1) the failure to submit a proper claim is due to the physical or mental capacity of the beneficiary. We advised you that if you assert that the failure to submit a proper claim is due to the physical or mental capacity of the beneficiary, you were required to submit medical records to support your assertion. We further advised you that i

which you are not without fault have been included in this demand.

letter, you are not without fault with respect to this overpayment.

check to: [u]

and is charged for each 30-day period that payment is delayed. (Periods of less than 30 days are treated as a full 30-day period. The current rate of interest is [b]&AR_INTEREST_RATE.[/b]) Medicare charges interest on its outstanding

claims. If you do not repay the debt
Treasury or a designated Treasury Debt Collection Center for offset against any monies payable to you by the Federal government or other collection actions.

You may include with this statement any evidence you believe is pertinent to your reasons why the recoupment should not be put into effect on the date specified above. [u]Your rebuttal statement and evidence should be sent to:[/u]

ten notice of our determination which will contain the rationale for our determination. However, recoupment will not be delayed beyond the date stated in this notice while we review your rebuttal statement. If put into effect, the recoup
refuse to grant an extended repayment schedule, and our response to any rebuttal statement are not initial determinations as defined in 42 CFR 405.704, and thus, are not appeal able determinations (see also, 42 CFR 401.625 and 405.3

the date of this letter). You have the right to challenge our finding that you are not without fault with respect to the overpayment at issue.

payments made to arrive at this total is enclosed.

payments made to arrive at this total is enclosed.

vii action against a third party on your clients behalf, seeking damages for injuries he/she received and medical expenses he/she incurred as a result of the above illness/injury.

when payment "has been made or can reasonably be expected to be made . . . under a Workers Compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." However, settling and accepting a final dollar amount in settlement of the claim with the third party. Medicare's claim must be paid up front out of settlement proceeds before any distribution occurs. Moreover, Medicare must be paid within 60 days.

release must be returned, even if a settlement has not yet been reached.)

are required to repay the Medicare program [b] & DEMAND_AMOUNT [/b] for Medicare's payments for medical care related to resolution of your workers' compensation claim. (The term "resolution" includes a settlement, judgment, award or settlement received by a Medicare beneficiary who has or may have a workers' compensation claim. However, the law also requires Medicare to recover those payments if the claim is favorably resolved. Congress passed the MSP law because it was determined that Medicare beneficiaries who receive workers' compensation benefits are required to repay. We have provided instructions for repaying Medicare in Part III of this letter. You have the right to appeal our determination if you disagree with it, and you also have the right to request that the Medicare program

received by a Medicare beneficiary who has or may have a workers' compensation claim. However, the law also requires Medicare to recover those payments if the claim is favorably resolved. Congress passed the MSP law because it was determined that Medicare beneficiaries who receive workers' compensation benefits are required to repay. We have provided instructions for repaying Medicare in Part III of this letter. You have the right to appeal our determination if you disagree with it, and you also have the right to request that the Medicare program

The Medicare program generally reduces the amount a Medicare beneficiary is required to repay to take into account the costs (such as attorneys' fees) [b] paid by the beneficiary [/b] to obtain resolution of your workers' compensation claim. If you have a workers' compensation claim, you must let us know.

to us at the address listed at the end of this letter. Please make sure to include your name and Medicare number on the check or money order and include a copy of this letter with your payment.

in, and you may request both a waiver and an appeal at the same time. The Medicare program may waive recovery of the amount you owe if you can show that you meet [b] both [b] of the following conditions:
complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment.

more specific information about your income, assets, expenses, and the reasons why you believe you should receive a waiver. If we are unable to grant your request for a waiver, we will send you a letter that explains the reason(s) for our determination [b] as explained in Part II of this letter. To file an appeal, you should send us a letter explaining why you think the amount you owe Medicare is incorrect and/or any reason(s) why you disagree with our determination. You may also

to you find a lawyer. There are also groups, such as legal aid services, that will provide free legal services if you qualify.

. You can find the regulation that explains interest charges at Section 411.24(m) of the regulations we identified in Part I of this letter. To avoid having to pay interest, you should repay Medicare in full within sixty (60) days of the date collection action is initiated. Interest is due first and then to the outstanding principal amount.

initiated, or from future Medicare payments. Medicare may also decide to refer any amounts you owe to the Department of Treasury for collection action. Before Medicare takes either or both of these actions, you will receive a written notice.

workers' compensation claim. Medicare will not pay for these future services until you demonstrate that the funds provided for these services have been properly spent. Secondly, when you receive these services in the future, you must advise us.

TRACT_STATE_TOLL_FREE_NUM [b] and the address listed below. Please also make sure that any letters you send us include your name, your Medicare Health Insurance Claim Number (this is the number found on your red, white, and

responsibility to reimburse Medicare arises upon payment of the funds by a third party regardless of whether liability or causation is established at trial or otherwise. (For Medicare's right to recover, see 42 U.S.C. §1395y(b)(2) and 42 CFR

You must notify the Medicare program if you receive any settlement, judgment, or award from any other source.

Waiver of recovery of the debt. If you succeed in an appeal or waiver request, the Medicare program will refund your money.

Medical expenses and injuries in its liability recovery demands to beneficiaries who receive a breast implant settlement, judgment, or award.

For a demand for damages; letters by you or on your behalf demanding recovery; statements from the manufacturer; any release that you executed as a part of your settlement, judgment, or award; and in the event that your case proceeds to a new determination explaining whether or not an adjustment has been made and setting forth your appeal rights with respect to the determination. That determination will replace this one for purposes of waiver of recovery and appeal rights.

We are asking for information about your income, assets, and expenses, and requesting that you explain why you believe you are entitled to waiver of recovery. We will notify you if recovery of some or all of the amount you owe can be waived. You must act within sixty (60) days of receiving this notice so that both appeals may be resolved efficiently. To appeal, you should send your request in writing to [b] &CONTRACTOR_NAME, &CONTRACTOR_ADDRESS1, &CONTRACTOR_ADDRESS2, &CONTACT

tted an adjustment claim, as is required in such situations. Additionally, you have not provided additional documentation in response to our letter of [b] [u]&LETTER_DT [/u]/[b] establishing that our records are incorrect. When provider
bt to the Department of the Treasury's Debt Collection Center for further collection actions, including offset of Federal payments.

ts outstanding Part A debts in accordance with Section 1815(d) of the Social Security Act (the Act) and 42 CFR 405.378. Medicare charges interest on Part B debts in accordance with Section 1833(j) of the Act and 42 CFR 405.

1996, we may refer your debt to the Department of Treasury or a designated Treasury Debt Collection Center for offset against any monies payable to you by at the Federal government or other collection actions.
easons why the recoupment should not be put into effect on the date specified above. [u]Your rebuttal statement and evidence should be sent to:[/u]

e principal of the debt and any assessed interest are liquidated: (2) we obtain a satisfactory agreement from you to liquidate the debt; or (3) on the basis of subsequently acquired evidence, we determine that there is no debt. If you cho

the cost report submission.

47.30, if we do not receive payment in full or an extended repayment request from you within 15 days from the date of this letter, we may initiate a request that your Federal share of Title XIX (Medicaid) be withheld, if applicable. If this
ds on any portion that remains outstanding until the debt is paid in full. Each payment will be applied first to accrued interest and then to principal. After each payment interest will continue to accrue on the remaining principal balance, at
bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

f you asert that you solicited the information necessary to identify third part payers primary to Medicare [b]at the time of services were provided or billed[/b], but that your were not provided the necessary information by the beneficiary c

Part A debts in accordance with Section 1815(d) of the Act and 42 CFR 405.378.

ment will remain in effect until the earliest of the following: (1) the overpayment and any assessed interest are liquidated; (2) we obtain a satisfactory agreement from you to liquidate the overpayment; or (3) on the basis of subsequent
75(c)).

r, Medicare may pay for a beneficiary's covered medical expenses conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgment or recovery.
s of receipt of proceeds from the third party. Interest may be assessed, if Medicare is not repaid in a timely manner. Repayment of Medicare's conditional payments must be made to the Medicare contractor handling this case.

or any other type of resolution.)

on waive recovery of the amount you owe in full or in part. Instructions for requesting waiver of recovery and appeal are provided in Part IV of this letter. Part V of this letter explains the interest charges that apply if you do not repay Me

nted to make sure that the Medicare Trust Funds would have enough money to pay for medical care that beneficiaries may need in the future. Congress decided that, if workers' compensation was available to pay for a Medicare benefici

claim. You can find the formula we use to decide how much the amount of this reduction should be at Section 411.37 of the regulations we identified in Part I of this letter. We have applied the formula and determined that the amount yo

ur decision and the steps you will need to follow to appeal that decision if it is less than fully favorable to you.

request an appeal by writing to the Centers for Medicare & Medicaid Services, other Medicare contractors, or the Social Security Administration. However, because we are the Medicare contractor responsible for handling your case, sendi

if this letter even if you decide to request a full or partial waiver of the amount you owe or decide to appeal our determination (see Part IV of this letter). If you receive a waiver of recovery or if you are successful in appealing our decisio

re informing you of Medicare's decision to do so.

se the provider that you are responsible for paying for these services rather than Medicare. You may wish to consider using a Medicare Set-Aside Arrangement as a way to put aside an amount approved by Medicare as adequate consid

blue Medicare card), and the date of the illness, injury or incident. Providing us with this information will help us respond to any questions you may have more quickly.

Part 411 beginning at 7411.20.)

led to trial, a court determination that particular illnesses or injuries were or were not a factor in determining the amount of the judgment or award.
ghts.

J. However, please note that if you have not furnished a copy of your settlement agreement, judgment or award (including information showing the settlement, judgment, or award amount), Medicare may not waive repayment of any pa
RACTOR_CITY, &CONTRACTOR_STATE, &CONTRACTOR_POSTAL_CODE. [/b]

s, physicians or other suppliers receive multiple primary payments, they are obligated to repay Medicare within 60 days from the date payment is received from the group health plan. As we have no record of repayment, an adjustment c

ose not to submit a rebuttal statement, the recoupment will automatically go into effect on [Insert Date]. Whether or not you submit a rebuttal statement, our decisions to recoup or delay recouping, to grant or refuse to grant an extend

withholding is initiated, it will not be removed until payment in full is received or an acceptable extended repayment request is received and approved.

: the rate of &AR_INTEREST_RATE percent.

or someone acting on his or her behalf, you were required to submit documentation to support your assertion; e.g., a copy of an insurance information request form signed by the beneficiary or a printout of the questions asked and answers

y acquired evidence, we determine that there is no overpayment.

dicare within sixty (60) days from the date of this letter and tells you about certain actions Medicare may decide to take if you fail to repay the amount you owe. Part VI explains your obligations if the resolution of your workers' compensa

ary's medical care, workers' compensation should pay for the care and any amounts already paid by Medicare should be refunded to the Medicare Trust Funds.

ou owe Medicare is [b]&DEMAND_AMOUNT[/b] .

ing your request to us directly will be faster and more efficient. Once we receive your request for appeal, we will decide whether our determination that you must repay Medicare [b] &DEMAND_AMOUNT [/b] is correct and send you a letter

in, Medicare will refund amounts you have already paid.

ration for future medical expense. An attorney can advise you about whether you should consider this option and, if so, assist you in establishing the Medicare Set-Aside Arrangement. More information about Medicare Set-Aside Arrangem

rt of the amount you owe. Without documentation of the amount of your settlement, judgment or award, Medicare must assume tha

claim, or a valid documented defense, Medicare must recover at this time.

led repayment schedule, and our response to any rebuttal statement are n

rs provided showing the date the questions were asked and answered. We specific

ation claim included consideration for future medical expenses. F

er that explains the reasons for our decision. Our letter will also explain the steps y

ments may be obtained from the CMS Regional Office.


```
select a.paragraph_code, a.paragraph_description, b.version_name, b.version_description, b.EFFECTIVE_START_|
from cmsar.cmsar_letter_paragraphs a, cmsar.cmsar_letter_para_versions b, cmsar.cmsar_letter_para_sections c
where a.PARAGRAPH_ID = b.PARAGRAPH_ID
and b.effective_end_date is null
and b.PARAGRAPH_VERSION_ID = c.PARAGRAPH_VERSION_ID
order by a.paragraph_code, c.section_type_seq
```

DATE, b.EFFECTIVE_END_DATE, c.section_type, c.section_type_seq, c.section_text, c.section_lang

DEFINITION	LETTER LANGUAGE
ALLOWED AMOUNT GREATER THAN THE REASONABLE CHARGE	Our records indicate that the claim was paid with an incorrect allowance. This resulted in an inaccurate payment made to you.
BENEFICIARY DECEASED	Under Medicare Policy, payments can not be made for services performed beyond the date of death. Our records indicate that the billed date of service is after the beneficiary's date of death. Therefore, payment was made in error.
DUPLICATE PAYMENT - Contractor Error	The submitted dates of service(s) and procedures have been previously paid resulting in a duplicate payment to be made to you.
DUPLICATE PAYMENT- Physician/Supplier Error	The claim was incorrectly prepared causing a duplicate payment to be made to you.
FAILURE TO PROPERLY ASSESS DEDUCTIBLE	When the claim processed, the patient deductible was not properly assessed. Therefore, payment was made to you in error.
YEAR OF SERVICE	Our records indicate that the incorrect year of service has been reported. Therefore, the payment was made to you in error.

IF PAYEE:

PROV/BENE

PROV/BENE

PROV/BENE

PROV/BENE

PROV/BENE

PROV/BENE