

# DME MAC Jurisdiction C

## OFFSET REQUEST FORM

**For money that Medicare has requested:** To initiate a request for immediate offset of an overpayment, submit the information below and **attach** a copy of the first page of the demand letter to each form. Please complete and attach a separate form for each overpayment to be offset. This form must be received within 20 days of the demand letter to ensure proper handling and to possibly avoid the interest penalty.

**Fax Request to: 1-615-782-4477**

**\*Date of Overpayment Letter:** \_\_\_\_\_

**\*Provider/Supplier Number (PTAN):** \_\_\_\_\_

**\*Document/Claim Control Number:** \_\_\_\_\_

*For money Medicare requested this is the demand case (inquiry) number and/or accounts receivable number*

**\*Amount of Overpayment:** \_\_\_\_\_

**\*Beneficiary HICN:** \_\_\_\_\_

**\*Claim Number:** \_\_\_\_\_

**\*Date of Service:** \_\_\_\_\_

**IMPORTANT:** To initiate a request for claim adjustments, submit the MEDICARE DME MAC Jurisdiction C - *Reopening Request Form* located at <http://www.cignagovernmentservices.com>.

**\*Signature of Requestor:** \_\_\_\_\_

**\*Date of Faxed Request:** \_\_\_\_\_



CIGNA Government Services

