

# Part B

## OFFSET REQUEST FORM

**For money that Medicare has requested:** To initiate a request for immediate offset of an overpayment, fill out 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 date to ensure proper handling and to possibly avoid the interest penalty.

**Fax Request to: 615-782-4623**

**For overpayment referrals:** Requests for claim adjustments that are submitted via fax will be processed. Providers should fill out the *Offset Request Form* and attach a completed copy of the *Voluntary Refund Form* or additional documentation explaining overpayment if needed. Once claims have been adjusted and the accounts receivable created the debt will be immediately set up for offset. **Please note that a demand letter will still be generated.**

**Fax Request to: 615-782-4623**

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

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

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

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

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

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

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

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

**\*Reason for Refund:** \_\_\_\_\_

*\*For Overpayment Referrals only. These fields are required to ensure proper processing.*

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

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