



Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Provider Overpayment Disclosure Form

PROVIDER INFORMATION

Provider (agency) name: _____

Provider contact first name: _____ Last name: _____

Provider ID/Service Location (PID/SL): _____ NPI: _____

Physical address: _____ City: _____ State: _____ Zip: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Office telephone number: _____ Ext: _____ Fax number: _____

E-mail address: _____

REASON FOR OVERPAYMENT (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Collection from Medicare Part A | <input type="checkbox"/> Provider billed incorrect service date. |
| <input type="checkbox"/> Collection from Medicare Part B | <input type="checkbox"/> Erroneous duplicate payment for the same service date |
| <input type="checkbox"/> Collection from Medicare (not known if Part A or B) | <input type="checkbox"/> Provider billed for the service twice. |
| <input type="checkbox"/> Collection from auto insurance or workers' compensation insurance | <input type="checkbox"/> Collection from credit balance on patient account |
| <input type="checkbox"/> Collection from commercial health insurance | <input type="checkbox"/> Provider performed only a component of the entire service billed. |
| <input type="checkbox"/> Claim was paid to the wrong provider. | <input type="checkbox"/> Provider billed incorrectly. |
| <input type="checkbox"/> Cost report issues | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Wrong MassHealth member ID was on the claim. | |

1. Please provide written, detailed information about the overpayment(s). In the space below, describe the facts and circumstances surrounding the possible fraud, waste, abuse, or inappropriate payment(s) and its discovery, the period involved, and an assessment of the potential financial impact. Attach additional sheets, if needed.

2. Cite the MassHealth regulations or policies potentially implicated or violated. Enter "not known" if you do not know. Attach additional sheets, if needed.

3. Identify the underlying cause(s) of the issue(s) involved, specify the nature and extent of any investigation or audit you conducted to identify the overpayment, describe any corrective action taken to address the problem leading to the overpayment, and identify the date the correction occurred and the process for monitoring the issue to prevent recurrence. Attach additional sheets, if needed.

4. Identify the individuals involved in any suspected improper or illegal conduct.
Attach additional sheets, if needed.

First name: _____ Last name: _____

Title/Position: _____

First name: _____ Last name: _____

Title/Position: _____

First name: _____ Last name: _____

Title/Position: _____

5. Provide a list of claims that comprise the overpayments. For each claim, provide the member's name and MassHealth ID number, the claim ICN and line detail number, date of service, service code, modifier, units, amount paid by MassHealth, amount paid by a third-party liability (TPL) insurer, and the amount of the overpayment. If there are more than five claims, then the claims must be formatted in an Excel spreadsheet or Access database and transmitted via secure e-mail, or placed on an encrypted CD and mailed with this form.

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____

ICN: _____ Line Detail: _____ Dates of service: _____

Service code: _____ Modifier: _____ Units: _____

Paid amount: _____ TPL: _____ Overpayment: _____

Member name: _____ Member ID: _____
ICN: _____ Line Detail: _____ Dates of service: _____
Service code: _____ Modifier: _____ Units: _____
Paid amount: _____ TPL: _____ Overpayment: _____

6. If applicable, provide the primary payor health insurance information. If there is more than one member, then the information must be formatted in an Excel spreadsheet or Access database and transmitted via secure e-mail, or placed on an encrypted CD and mailed with this form.

Member name: _____ Member ID: _____
Policyholder name: _____ Policy no: _____
Employer name: _____ Group no: _____
Insurance company name: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone number: _____ Fax number: _____
E-mail address: _____

List below any family members who are on the health insurance policy:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

7. If applicable, provide information about any federal or state agency involvement.

State or federal agency and/or law enforcement notified:

☐ State ☐ Federal ☐ Law enforcement ☐ Other (Specify): _____

Agency notified: _____ Date notified: _____
Contact person: _____ Title: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone number: _____ Fax number: _____
E-mail address: _____

8. Provide your contact information.

Contact person: _____ Title: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone number: _____ Fax number: _____
E-mail address: _____

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider or authorized representative *(if legal entity)*

(Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity are not acceptable.)

Printed legal name of provider

Printed legal name of authorized representative and person's title *(if the provider is a legal entity)*

Date

Mail the completed Provider Overpayment Disclosure Form to MassHealth at the address below.

MassHealth—Provider Compliance Unit
529 Main Street, Schraffts Center
Box #26, 3rd Floor, Suite 320
Charlestown, MA 02129-1120

In addition to mailing the completed Provider Overpayment Disclosure Form, the provider is urged, in the interest of time expediency, to e-mail the completed form to providercomplianceunit@umassmed.edu.

Providers should take precautions appropriate for the transmission of personal information and, in no case, should member names and MassHealth identification numbers or social security numbers be transmitted without using secure e-mail. MassHealth recommends that providers use a secure e-mail site to encrypt all electronic communications. If providers do not have access to a secure e-mail site and would like to use the one maintained by the MassHealth Provider Compliance Unit to transmit personal information or to transmit the Provider Overpayment Disclosure Form, they should send an e-mail requesting access instructions to providercomplianceunit@umassmed.edu.