The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Clear Form Print Form

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 code: _____

Mailing address: _____ City: _____ State: _____ ZIP code: _____

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

E-mail address: _____

REASON FOR OVERPAYMENT (Check all that apply.)

- ☐ Collection from a Third-Party Insurer
- ☐ Collection from Auto Insurance or Worker's Compensation
- ☐ Claim was paid to the wrong provider
- ☐ The claim was billed incorrectly, i.e., service date, member ID, procedure code, or modifier
- ☐ A partial component of a major service the service billed
- ☐ Overpayment related to a Rate Change
- ☐ Claim did not pay appropriately
- ☐ Claim paid for services not rendered
- ☐ Claim paid for services not covered
- ☐ Collection from a credit balance on a patient account, i.e., Patient Paid Amount
- ☐ Other (specify):

1. Please provide written, detailed information about the overpayment(s). Attach additional sheets, if needed.

2. If there is a system related overpayment, 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.

3. Providers are required to submit **all** claims on a password-protected Excel spreadsheet along with a completed Provider Overpayment Disclosure Form. For each claim, provide the member's name and MassHealth ID number, the claim ICN, date of service, procedure code, amount paid by MassHealth, amount paid by a third-party liability (TPL), and the amount of the overpayment. All communications to MassHealth concerning this disclosure should be transmitted via secure e-mail. If you do not have the appropriate software, a secure link can be provided to you upon request by emailing providercomplianceunit@umassmed.edu.

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

The provider is encouraged to email 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.