Instructions: Please complete this form, and submit it to the address or fax number appearing above. Please be sure to address your mailing or fax to: MIVS, Attn: Benefit Recovery-Credit Balance Reporting.

Provider Information

Provider Name: ______________________________________

Provider Legacy Number: ______________________________________

Provider NPI Number: ______________________________________

Provider Type: ______________________________________

Quarter Ending Date: (Please circle the appropriate date.)

Q1: March 31  Q2: June 30  Q3: September 30  Q4: December 31

Beneficiary Information

Beneficiary Name: ______________________________________

Medicaid ID Number (MID): ______________________________________

Claim Control Number (CCN): ______________________________________

Admission Date: ___________  Discharge Date: ___________  Claim Paid Date: ___________

Reimbursement Information

Total Amount Medicaid Paid: ______________________________________

Amount of Medicaid Credit Balance Repaid: ______________________________________

Method of Payment: (Please check one.)

☐ Check Enclosed
☐ Auto-debit Requested

Amount of Medicaid Credit Balance Outstanding: ______________________________________

Reason for Medicaid Credit Balance: (Please check one.)

☐ Provider Health  ☐ Estate
☐ Medicare  ☐ Casualty

Preparer’s Name (Please print)  Preparer’s Signature  Date

Preparer’s Contact Telephone Number: ______________________________________

Revised 02/2017