MEDICARE HHH Jurisdiction 15 Redetermination Request Form

Provider Information

Provider Name:

PTAN: NPI:

Address:

City:

State: Zip Code:

Phone Number:

HOME HEALTH (15004)

HOSPICE (15004)

Beneficiary Information

Patient Name:

Medicare Number:

Requestor's Name/Provider Contact Name:

Requestor's Signature: ***Signature not required as of July 8, 2019!***

Overpayment Appeal: If yes, then check: MR UPIC CERT RAC Other

Date of Service: Date of Initial Determination: DCN: Denied Services:

Note: Only one claim number per form should be submitted. Multiple claims per submission will not be acknowledged for processing.

Suggested Documentation Checklist: Medicare Remittance Advice; Advance Beneficiary Notice; Physician's Written Order; Signed Medical Documentation

Reasons/Rationale:

Mail: CGS - HHH Correspondence
CGS Administrators, LLC
PO Box 20014
Nashville, TN 37202

myCGS: See myCGS User Manual, Chapter 7: Forms Tab,
http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf

esMD: CMS website, esMD Information for Provider,
https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information_for_Providers.html

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