

# SECOND LEVEL SCREENING DOCUMENTATION

## JURISDICTION 15 HH&H WRITTEN CORRESPONDENCE

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### PROVIDER INFORMATION:

Provider's Name: \_\_\_\_\_

PTAN: \_\_\_\_\_

NPI: \_\_\_\_\_

Last 5 Digits of Tax ID: \_\_\_\_\_

Provider's Contact Name: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Extension: \_\_\_\_\_

### BENEFICIARY INFORMATION

Beneficiary's Medicare Number: \_\_\_\_\_

Beneficiary's Name: \_\_\_\_\_

### CLAIM/CORRESPONDENCE INFORMATION

ITN/DCN: \_\_\_\_\_

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

**Fax Number:** Jurisdiction 15 HH&H  
1.615.664.5906

**Instructions:** The Second-Level Screening form is used by providers or suppliers who have received a request for documentation from Complaint Screenings or the Benefit Integrity Unit. The completed form should be faxed with the request letter and any necessary documentation to the fax number on the request letter.