JURISDICTION 15 PART A
CLERICAL ERROR REOPENING ADJUSTMENT REQUEST FORM

Check all that apply ☐ Kentucky ☐ Ohio ☐ MSP **Date**

Contact

PROVIDER INFORMATION

Provider Name **Last 5 digits of Tax ID Number**

Billing PTAN Number **Billing NPI Number**

Address

BENEFICIARY INFORMATION

Name

Medicare Number **TOB**

Claim Dates of Service (DOS) **Document Control Number (DCN)**

Note: If multiple DCN's, submit individual form for each DCN.

REASON FOR REQUEST

This request is for a Medicare Secondary Payer (MSP) Reopening Adjustment Request ☐

Request to override timely filing ☐

Other (please explain circumstances for the reopening request) ☐

SUPPORTING DOCUMENTATION

Note: UB04 Form is required for all reopening requests. The UB04 is the only acceptable format (not UB92 or 1500 forms). Forms not filled out completely will be returned unprocessed.

UB04 Form (required) ☐ **Primary EOB** ☐ **Timely Filing Override** ☐

Contact Name

Contact Phone Number **Signature**

Completed form along with supporting documentation can be mailed to address below, or faxed to: 1.615.660.5982

CGS Administrators, LLC
J15 Part A Claims
PO Box 20211
Nashville, TN 37202

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