PART A OVERLAP DISPUTE REQUEST FOR ASSISTANCE

Provider Information

Provider Name | Last 5 digits of Tax ID Number

Billing PTAN Number | Billing NPI Number

Contact Name | Contact Phone Number

Address

Beneficiary Information

Beneficiary Name | Medicare Number

Claim Dates of Service (DOS) | Admission Date (if applicable)

Type of Bill (TOB) | Reason Code Received

Document Control Number (DCN)

NOTE: If multiple DCN’s, submit individual form for each DCN

Overlapping Claim Information

Claim DCN | Dates of Services (DOS)

Provider Number (PTAN) | NPI Number

Contact Information for Overlapping Facility

Facility Name | Facility Phone Number

1st Contact Attempt
Date and Time of Contact | Contact Name

2nd Contact Attempt
Date and Time of Contact | Contact Name

3rd Contact Attempt
Date and Time of Contact | Contact Name

Reason Dispute
Is Unresolved:

Form can be faxed to **(615) 660-5982** or mailed to address below.

CGS Administrators, LLC
PO Box 20211
Nashville, TN 37202

Please submit any necessary documentation (i.e., admit/discharge papers).

Forms not filled out completely will be returned unprocessed.

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