Notification of Disputed Home Health Agency (HHA) Transfer

The form below should be completed by the initial HHA to request assistance in resolving a transfer dispute with the receiving HHA under Home Health Prospective Payment System (HH PPS). Every attempt must be made to resolve the dispute prior to submitting the form or contacting CGS. This form must be mailed to the following address, or faxed to: 1.615.660.5063

J15—HHH Correspondence
CGS
PO Box 20014
Nashville, TN 37202

Initial Home Health Agency Information	
Provider Name	
Provider Number	
National Provider Identifier (NPI)	
Tax Identification Number	
Telephone Number	
Patient's Medicare Number	
Patient's First and Last Name	
Date of First Visit	
Date of Last Visit	
Episode Dates (from – to)	

Disputed (Overlapping) Home Health Agency Information	
Overlapping Provider Name	
Provider Number	
Telephone Number	
Overlapping Episode Dates (from and through)	

Contact Information with Disputed (Overlapping) Home Health Agency - Minimum of 3 contacts required	
Date of 1st Contact	
Time	
Contact Name	
Date of 2nd Contact	
Time	
Contact Name	
Date of 3rd Contact	
Time	
Contact Name	
Reason dispute is unresolved	

Admission Documentation - All admission documentation must be submitted with this form or your request will be denied.	
Name of Person Completing Form	
Telephone Number	
Date Completed	