STOP PAYMENT AFFIDAVIT

HH&H KY Part B OH Part B KY Part A OH Part A
DME MAC Jurisdiction C DME MAC Jurisdiction B

Date

PLEASE FILL IN THIS SECTION COMPLETELY

CHECK INFORMATION

Check Date
This form can only be used for checks that are more than 30 days, but less than one year old.

Check Amount

Check No

Mark if check DOES NOT need to be reissued

Contact Person

PAYEE INFORMATION

Beneficiary Medicare No.

Or Provider/Supplier PTAN

Name

Address

Contact Phone

In order to request a replacement check for the original Medicare payment that was either lost or not received, please complete and return this form. When someone other than the payee signs the form, please indicate the relationship.

The above referenced check was: (Check the appropriate statement)

1. Not received and not endorsed, nor have I authorized any endorsement.
2. Received and lost, but has not been endorsed, nor have I authorized any endorsement.
3. Received and lost, and endorsed as follows:

I hereby request that **CGS** place a stop payment on the above referenced check and issue a replacement check, unless noted otherwise above. In consideration, I hereby agree that if the original check should be presented bearing any personal or authorized endorsement, to reimburse **CGS** for any loss, claim, damages, or expense whatsoever in any manner arising there from. **In the meantime, if I receive the above referenced check, I will notify CGS.**

SIGNATURE DATE

RELATIONSHIP TO PAYEE

REMARKS

FAX NUMBERS:

DME JB/JC: 1.615.782.4477 **KY B:** 1.615.664.5916 **OH B:** 1.615.664.5926 **Part A/HH&H:** 1.615.664.5958

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