SECOND LEVEL SCREENING DOCUMENTATION

JURISDICTION 15 PART A WRITTEN CORRESPONDENCE

State: Kentucky ☐ Ohio ☐

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 Part A
1.615.664.5910

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 or mailed with the request letter and any necessary documentation to the fax number or address located on the request letter.

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