Medicare Part B

Billed Amount Adjustment Request Form
Units Adjustment Request Form
Units and Billed Amount Adjustment Request Form

UBA 817

General Information

State Kentucky ☐ Ohio ☐ Date

Contact Phone Number

Provider Information

Name Last 5 digits of Tax ID Number

Billing PTAN Number Billing NPI Number

Beneficiary Information

Name

Medicare Number

Service Date HCPCS ICN (one claim per form)

Adjustment Details

Line	Adjustment Type *B = Billed Amount, U = Units, Y = Both*	New Value *Units*	New Value *Billed Amount*

Send to
J15 - Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202

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CGS® CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES