MEDICARE PART B REOPENINGS ADJUSTMENT REQUEST FORM

State:	☐ Kentucky ☐ Ohio	Date:	

Contact:	http://www.cgsmedicare.com/partb/help/contact/contactinfo.html#adjustments

Provider Information:

Name:		Last 5 digits of Tax ID #:	
Billing PTAN #:		Billing NPI #:	
Address:			
Phone #:			

Beneficiary Information

Name:	
Medicare #:	
Address:	
Phone #:	

Service Date:	HCPCS:	Internal Control Number (ICN):

NOTE: If Multiple ICNs, you may attach a detailed remit with this information

Reason for Request:

☐ This request is for an Medicare Secondary Payer (MSP) Reopenings Adjustment Request
Was EOB submitted with intial claim? ○ Yes ○ No

☐ This request is for CGS to cancel this claim.
If claim was paid, submit Overpayment Refund form.

☐ The beneficiary information is incorrect (i.e. wrong beneficiary name, HICN).
If claim was paid, submit Overpayment Refund form.

☐ Other: ____

Send to:

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

Supporting Documentation

☐ CMS 1500 Form ☐ Primary EOB ☐ Medicare Remittance Notice ☐ Advance Beneficiary Notice

☐ Other: ____

Form Completed by:	
Signature:	

Form revised March 16, 2012.

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