

# Medicare Part B Fax/Mail Cover Sheet

This form should not be used to fax CGS request for additional documentation.  
Please continue to attach documentation to the ADS letter and mail to CGS.

**Complete all fields** and fax the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare Fax Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN (optional):	CPT/HCPCS code:	
<i>Exactly as entered in the PWK loop on the claim</i>		
Beneficiary Last Name:	Beneficiary First Name:	Medicare ID:
Date(s) of Service (from):	Date(s) of Service (to):	Total Claim Billed Amount:
Billing Provider's Name:	PTAN:	
Contact and Phone Number:	NPI:	
State Where Services Were Provided:	Total Number of Documentation Pages (including cover sheet):	

Notes:

## SENDER INFORMATION:

Name:	Fax Number:
Company Name:	Phone Number:

Address:

City:	State:	Zip:
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<b>Fax Number:</b>	<b>Address (Kentucky and Ohio):</b> CGS
CGS – Ohio . . . . . 1.615.664.5953	PO Box 20018
CGS – Kentucky . . . 1.615.664.5952	Nashville, TN 37202

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