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:

Exactly as entered in the PWK loop on the claim

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:

Fax Number:
CGS – Ohio 1.615.664.5953
CGS – Kentucky . . 1.615.664.5952

Address (Kentucky and Ohio): CGS
PO Box 20018
Nashville, TN 37202

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Revised March 26, 2018.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES