

J15 Medicare Therapy Cap Exception Form

Please TYPE this form instead of handwriting to ensure an efficient review.

Date: _____

Fax to: CGS

Part A OH 1.615.664.5946
Part A KY 1.615.664.5944
Part B OH 1.615.664.5973
Part B KY 1.615.664.5963
Home Health & Hospice 1.615.664.5993

Mail to:

Part A - CGS Therapy Cap Exception Request
PO Box 23558
Nashville, TN 37228

Part B - CGS Therapy Cap Exception Request
PO Box 24357
Nashville, TN 37228

HHH - CGS Therapy CAP Exception Request
PO Box 23468
Nashville, TN 37228

Region (select one)	Part A OH	Part A KY	Part B OH	Part B KY	HHH
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Performing Provider Information

Performing Provider Name _____

Performing Provider No _____

Performing Phone No _____

Performing Provider Street Address _____

Performing Provider City _____ State _____ Zip _____

Ordering Provider Information

Ordering Provider Name _____

Ordering Provider No _____

Ordering Provider Street Address _____

Ordering Provider City _____ State _____ Zip _____

Beneficiary Information

Beneficiary Name (first, middle initial and last) _____

Beneficiary HICN _____

Beneficiary Phone No _____

Beneficiary Street Address _____

Beneficiary City _____ State _____ Zip _____



J15 Medicare TCE Form Continued

Type of Therapy/Service (select one)

Physical Occupational Speech Pathology Physical/Speech

This is the first request for this Type of Therapy. Yes No

Additional therapy treatment days for this Type of Therapy have been approved previously. Number of days

Additional Therapy treatment days for this Type of Therapy were previously requested and denied.
Has the beneficiary's condition changed significantly since the previous request for exception? Yes No

If yes, describe the change in condition

Additional Therapy Days (not to exceed 20)

Number of days requested

Date range of services from Date of services to

Reason for Request

ICD-9 Diagnosis Code(s) of Principal Condition/Complexity Necessitating.

Additional Treatment Days:

Documentation

List each document included with the request for exception (evaluation, re-evaluation, plan of care, progress notes, encounter notes, etc.). Documentation must be sufficient to support continued progress with current therapy.

1.

2.

3.

4.

5.

6.
