SUGGESTED REFILL REQUEST FORM

This is not a required form. CGS created this form to help you obtain documentation to support a request for a refill for **dates of service on or after January 1, 2024**.

SUPPLIER INFORMATION

Company Name	
Employee Name and Title	

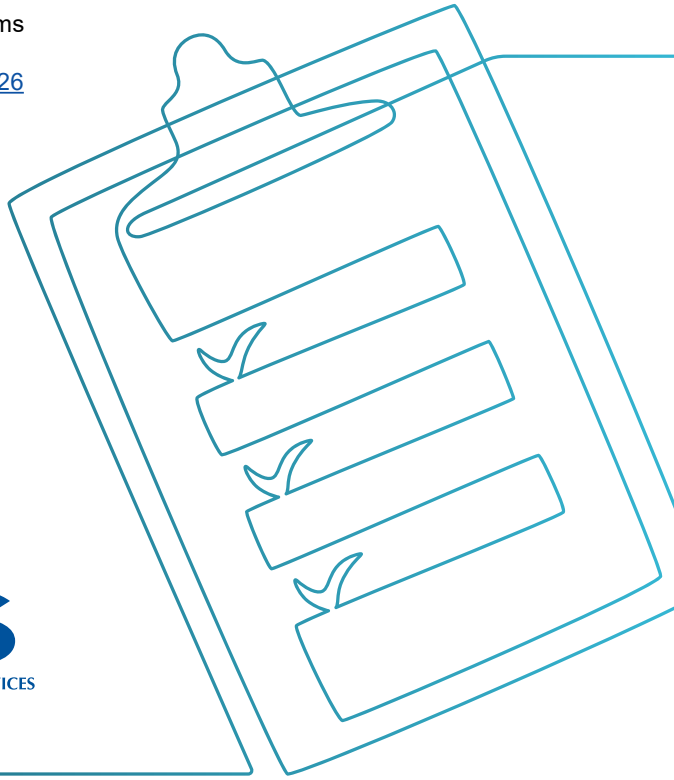
BENEFICIARY INFORMATION

Name	
Authorized representative, if applicable. *Include the relationship to the beneficiary (strongly recommended).*	
Patient ID	
Date of Refill Request	

REQUESTED ITEM(S)

1	Description of item requested:	
	Beneficiary or authorized representative affirmed need for refill:	☐ Yes ☐ No
2	Description of item requested:	
	Beneficiary or authorized representative affirmed need for refill:	☐ Yes ☐ No
3	Description of item requested:	
	Beneficiary or authorized representative affirmed need for refill:	☐ Yes ☐ No

Refer to Policy Article A55426 “Standard Documentation Requirements for All Claims Submitted to DME MACs”.
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426



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