

# SUGGESTED REFILL REQUEST FORM

## SUPPLIER INFORMATION

Company Name	
Employee Name and Title	

## BENEFICIARY INFORMATION

Name	
Medicare number	
Date of Contact with Beneficiary	

## REQUESTED ITEM(S)

<b>1</b>	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): ----- Replacement reason:

<b>2</b>	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): ----- Replacement reason:

<b>3</b>	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): ----- Replacement reason:

<b>4</b>	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): ----- Replacement reason:

Refill Request (authorized by):	
Relationship with the Beneficiary (if applicable):	

This is a suggested Refill Request Form, The use of this form is optional. Please refer to the DME MAC Jurisdiction B Supplier Manual, Chapter 3 for a detailed description of documentation requirements regarding Refill Request: <http://www.cgsmedicare.com/jb/pubs/pdf/chpt3.pdf>



A CELERIAN GROUP COMPANY

