DME MAC Jurisdiction C

Medicare PWK Fax/Mail/esMD Cover Sheet

INSTRUCTIONS FOR COMPLETING PWK COVER SHEET

Medicare PWK Fax/Mail/esMD Cover Sheet

This form should be completed by anyone submitting PWK segments with their electronic claims. It must be filled out completely or the request will be denied. A coversheet must be submitted with each electronic PWK claim.

Field Descriptions	
Field Name	**Instructions for Field Completion**
ACN:	The Attachment Control Number (ACN) is used to identify the documentation. This is submitted on the claim. The ACN is user defined, with a maximum field length of 50.
CCN:	The Claim Control Number (CCN) of the claim in which you are submitting PWK. The CCN can be located on the TRN277CA.
Beneficiary:	**Last Name:** Last name of the beneficiary on the claim
	First Name: First name of the beneficiary on the claim
Medicare ID:	Medicare ID of the beneficiary on the claim.
Date(s) of Service:	**From:** The "From" date of service on the claim
	To: The "To" date of service on the claim
NPI:	The 10 digit NPI number issued by the NPI Enumerator for the supplier, as submitted on the claim
Total Number of Documentation Pages:	Total number of pages (cover sheet & documentation) being submitted to CGS
PTAN:	The 10 digit PTAN that corresponds to the NPI submitted on the claim
Notes:	Notes about the documentation/claim (optional)
Sender Information:	
Name:	Your name
Fax #:	If submitting PWK by fax, provide your fax number. If the submission is rejected due to an incomplete coversheet it will be faxed to you.
Company Name:	Name of your company
Address:	Your complete individual or company mailing address
City:	
State:	
Zip:	

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

ACN: (Exactly as entered in the PWK loop on the claim):		CCN:
Beneficiary: Last Name	First Name	Medicare ID:
Date(s) of Service: From	To	NPI:
Total Number of Documentation Pages (including cover sheet):		PTAN:

Notes:

Sender Information		
Name:	Fax #:	
Company Name:		
Address:		
City:	State:	Zip:

CGS Fax Number: 1.615. 664.5954

CGS Address: CGS
PO Box 20010
Nashville, TN 37202