PART A DISPUTE REQUEST FOR ASSISTANCE

This form should be completed by the initial Skilled Nursing Facility or Inpatient Hospital provider to request assistance in resolving an overlap situation with another Medicare provider. Every attempt must be made to resolve the dispute prior to submitting the form or contacting CGS.

The form must be mailed to the following address, or faxed to: **1.615.660.5982**

J15-Part A Claims
CGS Administrators, LLC
PO Box 20211
Nashville, TN 37202

Initial Skilled Nursing Facility or Inpatient Hospital Information

Provider Name

Provider Number

National Provider Identifier (NPI)

Tax Identification Number | Telephone Number

Patient's Medicare Number

Patient's First and Last Name

Date of First Visit | Date of Last Visit

Reason Code Received

Overlapping Provider Information

Overlapping Provider Name

Provider Number | Telephone Number

Overlapping Dates (from and through)

Contact Information with Overlapping Provider (minimum of 3 contacts required)

Date of 1st Contact	Contact Name	Time
Date of 2nd Contact	Contact Name	Time
Date of 3rd Contact	Contact Name	Time

Reason Dispute
Is Unresolved:

Documentation

Please submit any necessary documentation (i.e. admit and discharge documents).

Name of Person Completing Form

Telephone Number | Date Completed

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CENTERS FOR MEDICARE & MEDICAID SERVICES