

SECOND LEVEL SCREENING DOCUMENTATION

JURISDICTION 15 PART B WRITTEN CORRESPONDENCE

State: Kentucky Ohio

PROVIDER INFORMATION:

Provider's Name: _____

PTAN: _____

NPI: _____

Last 5 Digits of Tax ID: _____

Provider's Contact Name: _____

Contact Phone Number: _____

Extension: _____

BENEFICIARY INFORMATION

Beneficiary's Medicare Number: _____

Beneficiary's Name: _____

CLAIM/CORRESPONDENCE INFORMATION

ITN/CCN: _____

Date of Service: _____

Fax Number: Jurisdiction 15 Part B
1.615.664.5921

Instructions: The Second-Level Screening form is used by providers or suppliers who have received a request for documentation from Complaint Screenings or the Benefit Integrity Unit. The completed form should be faxed or mailed with the request letter and any necessary documentation to the fax number or address located on the request letter.