national government SERVICES

A CMS Medicare Administrative Contractor

MEDICARE

Jurisdiction 6 COVID-19 Accelerated and Advance Payment CAAP Debt Dispute Request

Provider/ Supplier Name: _____

Provider/ Supplier NPI (required) _____

Provider/ Supplier Medicare ID (required) _____

Accounts Receivable Number (required) _____

Reason for Disagreeing (required)

☐ Amount has been paid in full

☐ Amount is inaccurate as of the date of the demand letter. The amount owed should be $_____ as of _____ (Date).

**Providers/ suppliers must attach documentation to substantiate both options, including an explanatory statement supported by documents or account statements such as the Repayment Status Letters.

Provider/ Supplier's Authorized or Delegated Official (required) _____

Telephone Number _____

Preferred Communication for Response

☐ Email

☐ First Class Mail (CMS will use the correspondence address on file for demand letters)

Email Address _____

Date (required) _____

By submitting the CAAP Debt Dispute the listed individual certifies they are an authorized representative that is legally able to make commitments and assume obligations on the provider's behalf.

Contact Information

Authorized or Delegated Official's Name (required)_____

Authorized or Delegated Official's Signature required): _____

Mail this completed form to:

National Government Services
Attn: Overpayment Recovery Unit
P.O. Box 6474
Indianapolis, IN 46206-6474