National Government Services

A CMS Medicare Administrative Contractor

Educational Review Request
Partnering for Education

Educational Review Request Coversheet
Positive Airway Pressure Devices

- ☐ **Initial Coverage**
- ☐ **Continued coverage beyond the first three months**
- ☐ **Replacement**
  - ☐ **During 5 year reasonable useful life (RUL)**
  - ☐ **Following five year RUL**
- ☐ **Beneficiaries entering Medicare with a PAP device prior to fee-for-service (FSS) Medicare enrollment**

**Fields with asterisks are required*

***Has the item been delivered?** Yes ☐ No ☐

First Request ☐

Final Request ☐

Request Date ____________________

*HCPCS ____________________

Intended Modifier(s) ____________________

*Number of Pages (including coversheet) ____________________

*Supplier Name ____________________

Supplier Address ____________________

Note: Your decision letter will be sent to the correspondence/remittance address that we have on file unless otherwise indicated on the coversheet.

*Contact Name ____________________

*Contact Phone Number ____________________ Supplier Fax ____________________

Supplier NPI ____________________

*Supplier PTAN ____________________

*Physician/Treating Practitioner (TP) Name ____________________

Physician/TP Address ____________________

*Physician/TP NPI ____________________

Sleep Interpreting Physician Name ____________________

Sleep Interpreting Physician Phone Number ____________________

*Beneficiary Name ____________________

*Beneficiary HICN ____________________

*Beneficiary Date of Birth ____________________

Beneficiary Address ____________________

Please submit the following documentation via **FAX 315-442-4053**.

- ☐ Completed coversheet
- ☐ Written order prior to delivery
- ☐ Face-to-face examination (if applicable)
- ☐ Proof of delivery (If the request is after date of delivery)
- ☐ Sleep test (for PAP device)
- ☐ Interpretation of sleep test
- ☐ Objective documentation of adherence (if applicable)

Mail

National Government Services, Inc.
Attn: POE-Educational Review Request
P.O. Box 7149
Indianapolis, IN 46207-7149

For additional information, visit the Jurisdiction B DME MAC website at http://www.NGSMedicare.com.

The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your claim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the Centers for Medicare & Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

CMS
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