

Educational Review Request Coversheet

- | | |
|---|---|
| <input type="checkbox"/> Group 2 Pressure Reducing Support Surfaces | <input type="checkbox"/> Therapeutic Shoes for Persons with Diabetes |
| <input type="checkbox"/> Hospital Beds | <input type="checkbox"/> Standard Manual Wheelchair (K0001) – Manual Wheelchair Bases |

**Fields with asterisks are required*

*Has the item been delivered?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
First Request	<input type="checkbox"/>	
Final Request	<input type="checkbox"/>	

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 _____

*Beneficiary Name _____

*Beneficiary HICN _____

*Beneficiary Date of Birth _____

Beneficiary Address _____

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

- | | |
|---|---|
| <input type="checkbox"/> Completed coversheet | <input type="checkbox"/> Face-to-face examination (if applicable) |
| <input type="checkbox"/> Written order prior to delivery | <input type="checkbox"/> Medical documentation to support medical necessity |
| <input type="checkbox"/> Detailed Written Order (Therapeutic Shoes) | <input type="checkbox"/> Proof of delivery (If the request is after date of delivery) |
| <input type="checkbox"/> Dispensing Order (Therapeutic Shoes) | |

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 <https://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.