National Government Services
A CMS Contracted Agent

Medicare

Cover Sheet for Electronically Submitted Medical Records

Department Requesting Records: _____

Password to Open Files (if applicable): _____

Reason for Record Submission: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

Medicare Number: _____

Beneficiary Name: _____

Dates of Service: _____

Claim Number: _____

CMS
CENTERS for MEDICARE & MEDICAID SERVICES