Request for assistance -- resolve overlapping claims

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Date:

To:

☐ First
☐ Follow-up
☐ RO copy

Date of first request

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We request assistance in resolving CWF reject edit code:

The following action is requested:

Identifying information:

Medicare ID	Beneficiary name
Your ICN	Provider
From date	Through date

Explanation of action taken by assisting contractor:

Requestor Information

Response date

Final

Status

Return to (Requesting contractor)

Claim #:
Dates of service:
Provider:
Contact person:
Contact number:
Other:

Print Reset

Please print and fax (with supporting documentation) to 904-361-0784