REGION 4 RECOVERY AUDIT CONTRACTOR
DISCUSSION PERIOD SUBMISSION FORM
PART A: HOSPITALS/SKILLED NURSING FACILITIES

To: HMS Part A Discussion Period Review Fax: (702) 240-5595
From: ___________________________ Date: ___________________________
Phone Number: ____________________ Fax Number: ____________________
RE: ______________________________ Pages: __________________________

Is this a Peer-to-Peer Discussion Request? □ YES □ NO

Note: A physician or physician employed by the Provider, not a consultant, may request to hold discussions with HMS’ Medical Director. Please do not select “yes” if a physician employed with your facility is not requesting to hold discussions with HMS’ Contractor Medical Director and Review Staff.

Please review the attached additional materials and re-evaluate the original improper payment determination for:

HMS Audit Number: __________________________
Claim Number: ___________________________
Provider Name: ____________________________
Provider Number: __________________________
Comments: ___________________________________________________________________
____________________________________________________________________________

SUBMISSION INSTRUCTIONS:
You may submit this form and all additional materials by fax or mail.
NOTES:
1. Please submit one (1) form for each claim.
2. Please enclose a copy of the Audit Detail Page that is attached to the HMS letter
4. HMS will carefully review the materials you have submitted and provide you with a written response.

CMS RAC Part A Discussion Period Review
9275 W Russell Road, Suite 300 - MS 12M, Las Vegas NV 89148
Part A Provider Relations: (877) 350-7992 Fax: (702) 240-5595

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