

Attention Medicare Medical Review Unit

For Provider Use:

Provider Number _____

HIC Number _____ DCN _____

Dates of Service _____ to _____

Please indicate if:

PT Notes Attached _____ ST Notes Attached _____ OT Notes Attached _____

SNF MDS Attached _____ Demand MDS Attached _____

Itemized bill for Supply/Pharmacy _____

Ambulance _____ Cardiac Rehab _____ Cataract surgery _____

Chest X-Rays _____ CT Scan _____ EPO _____ HBO _____ Labs _____

MRI _____ MRA _____ Observation _____ PSYCH _____

Questionable Covered Procedure _____

Other (Specify) _____

For Wisconsin Physicians Service Medicare's use only:

Received _____ Analyzed _____ Region _____ Clerk # _____

Reason Code(s) _____ **MR Indicators:**
_____ MR HCPCS Code(s) _____

MR Decision _____
_____ MR Rev Code _____
_____ MR All _____

Medically reviewed by _____ Date _____

Overridden by _____ Date _____

For Support Services Use Only

Ok to File _____