CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

# Request for Cardiac Rehab Extension
# Attention: Medicare Medical Review Department

Provider Name ______________________________ Provider/NPI #_________________

Provider Contact ____________________________ Contact Phone #__________________

Provider Address ____________________________________________________________________

City _________________________________ State __________ Zip ____________________

Patient Name _______________________________ HIC# _________________________

Patient Diagnosis ____________________________ Start of Care Date _______________

# of Sessions to Date _________________ # of Extended Visits Requested ________________

**Please submit the following information via overnight mailing to:**

WPS-Medicare
Attention: Medical Review Department/ Cardiac Rehabilitation Extension
3333 Farnam Street, Suite 600
Omaha, NE 68131

☐ **All Cardiac Rehab Notes to include:**

- ☐ **Physician's Order**
  -specifying the length of the extension and the supporting diagnosis
- ☐ **Patient History and Physical**
- ☐ **All Exit Criteria**
  -summary of prior cardiac rehab progress (# of sessions attended, time frame, progress, patient compliance)
- ☐ **Relevant Tests and/or Diagnostic Procedure Results**
- ☐ **Telemetry Strips from Each Treatment**
- ☐ **Statement of Goals and/or Anticipated Benefit of Further Therapy Sessions**

☐ **Written Cardiac Rehab Extension Request from Physician**