Request to Open Discussion Period

(Updated 4/15/2013)

Our experience indicates that many of the discussions can be resolved more quickly and efficiently without the need for a teleconference, particularly when additional documentation is submitted to support the claim. **Upon receipt of your request, the auditor and, if needed, the Medical Director will determine if a telephone discussion is necessary or if a complete and appropriate response can be provided in writing based on the submitted documentation only. If a teleconference is necessary, you will be contacted to arrange a time. A letter will be sent detailing the outcome of each written or oral discussion.**

Instructions

Please submit a separate form for each issue to be discussed. Multiple claims reviewed for the same issue may be included on a single request. It is helpful to attach a copy of the pertinent Review Results or Demand letter with the documentation.

To ensure that your request is addressed as quickly as possible, please be sure to send the documents to the appropriate location listed below.

Mailing Address

You may submit this form and additional documentation by mail as below, or fax to:

DISCUSSION REQUEST FAX NUMBER For Illinois, Indiana, Kentucky, Michigan and Ohio and for DME and Home Health
216-687-4278

DISCUSSION REQUEST FAX NUMBER For Minnesota and Wisconsin
866-340-0626

Send medical records as follows:

Medical records for Indiana, Illinois, Kentucky, Michigan, Ohio, DME and Home Health:

CGI Federal Inc.
Attn: RACB Imaging Dept
1001 Lakeside Ave., Suite 800
Cleveland, OH 44114

Medical records for Minnesota and Wisconsin:

Attn: Medicare Recovery Audit Subcontractor - Region B
PO BOX 72488
Atlanta, GA 31139

Questions regarding this request should be directed to the RACB Call Center at 877-316-RACB (7222).

Note: Once an appeal is filed with the MAC, CGI must close the discussion request immediately. Please notify CGI if you have already filed an appeal.

Discussion Request Form

Provider/Supplier Name: ____

Provider Medicare Number: ____

Provider Representative:

Name: ____

Phone: ____

Fax: ____

Email: ____

RAC Letter:

Review Results Letter # ___________________ Date: _______________________

Claim Number(s): ____

Additional Documentation Attached: ☐ Yes ☐ No

I am contacting the RAC for the following reason(s):

__ I am submitting additional documentation to support the claim. (Written Discussion)

__ I am submitting Regulation or Direction from CMS or the AC to support the claim. (Written Discussion)

__ I do not have additional documentation to support the claim but wish to discuss the RAC determination for the following reason:

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__ Other:

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Please submit additional page(s), if necessary

Signature: ____________________________________ Date: _______________________

Printed Name: ____