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Wasteful and Inappropriate Service Reduction

Additional Documentation Request

Fax/Mail Cover Sheet

Complete all fields; attach supporting medical documentation and fax to **617-843-6857** or mail to the applicable address provided at the bottom of the page. Complete ONE (1) Fax/ Mail Cover Sheet per request.

Required Information		
Beneficiary Last Name:	Beneficiary First Name:	Date of Birth (YYYY-MM-DD):
Medicare ID:	Beneficiary Address:	
Rendering Provider/Facility Name:	Request Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	
Rendering Provider/Facility Address:	Rendering Provider/Facility Fax Number:	
Rendering Provider/Facility NPI:	Rendering Provider/ Facility CCN/PTAN:	
Ordering/Referring Physician Name:		
Ordering/Referring Physician Address (City, State and Zip):		
Ordering/Referring Physician NPI:	Ordering/Referring Physician CCN/PTAN:	
Claim Number:	Place of Service <input type="checkbox"/> 11- Office <input type="checkbox"/> 24- ASC <input type="checkbox"/> 12- Home <input type="checkbox"/> TOB 13X	
Diagnosis Code:		
Requestor Name and Address (City, State and Zip):		
Requestor Phone Number:	Requestor Fax Number:	Requestor email address:
Jurisdiction:	Date Submitted (YYYY-MM-DD):	Number of Pages (including coversheet):
Comments:		

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Important: Dates must be in YYYY-MM-DD format. Any other format may lead to dismissal without review.

Send form to:

**HUMATA HEALTH
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Clinical & Intake Help: wiser@humatahealth.com
General Support: wiser.support@humatahealth.com

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