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Humata Health

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: ☐ Part A ☐ 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 ☐ 11- Office ☐ 12- Home ☐ 24- ASC ☐ TOB 13X	
Diagnosis Code:		
Requestor Name and Address (City, State and Zip):		
Requestor Phone Number:	Requestor Fax Number:	
Jurisdiction:	Date Submitted *(YYYY-MM-DD)*:	Number of Pages (including coversheet):
Comments:		

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Send form to:

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