

# Medicare PWK Fax/Mail/esMD Cover Sheet

## INSTRUCTIONS FOR COMPLETING PWK COVER SHEET

### Medicare PWK Fax/Mail/esMD Cover Sheet

This form should be completed by anyone submitting PWK segments with their electronic claims. It must be filled out completely or the request will be denied. A coversheet must be submitted with each electronic PWK claim.

Field Descriptions	
Field Name	Instructions for Field Completion
<b>ACN:</b>	The Attachment Control Number (ACN) is used to identify the documentation. This is submitted on the claim. The ACN is user defined, with a maximum field length of 50.
<b>CCN:</b>	The Claim Control Number (CCN) of the claim in which you are submitting PWK. The CCN can be located on the TRN277CA.
<b>Beneficiary:</b>	<b>Last Name:</b> Last name of the beneficiary on the claim
	<b>First Name:</b> First name of the beneficiary on the claim
<b>Medicare ID:</b>	Medicare ID of the beneficiary on the claim.
<b>Date(s) of Service:</b>	<b>From:</b> The "From" date of service on the claim
	<b>To:</b> The "To" date of service on the claim
<b>NPI:</b>	The 10 digit NPI number issued by the NPI Enumerator for the supplier, as submitted on the claim
<b>Total Number of Documentation Pages:</b>	Total number of pages (cover sheet & documentation) being submitted to CGS
<b>PTAN:</b>	The 10 digit PTAN that corresponds to the NPI submitted on the claim
<b>Notes:</b>	Notes about the documentation/claim (optional)
<b>Sender Information:</b>	
<b>Name:</b>	Your name
<b>Fax #:</b>	If submitting PWK by fax, provide your fax number. If the submission is rejected due to an incomplete coversheet it will be faxed to you.
<b>Company Name:</b>	Name of your company
<b>Address:</b>	Your complete individual or company mailing address
<b>City:</b>	
<b>State:</b>	
<b>Zip:</b>	

# Medicare PWK Fax/Mail/esMD Cover Sheet

**Complete all fields** and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete **ONE (1)** Medicare PWK Fax/Mail/esMD Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim.

ACN: (Exactly as entered in the PWK loop on the claim):		CCN:
Beneficiary: Last Name	First Name	Medicare ID:
Date(s) of Service: From	To	NPI:
Total Number of Documentation Pages (including cover sheet):		PTAN:

Notes:

Sender Information		
Name:	Fax #:	
Company Name:		
Address:		
City:	State:	Zip:

**CGS Fax Number:** 1.615.782.4511

**CGS Address:** CGS  
PO Box 20007  
Nashville, TN 37202

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