SUGGESTED REFILL REQUEST FORM

SUPPLIER INFORMATION

Company Name	
Employee Name and Title	

BENEFICIARY INFORMATION

Name	
HICN	
Date of Contact with Beneficiary	

REQUESTED ITEM(S)

1	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): Replacement reason:

2	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): Replacement reason:

3	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): Replacement reason:

4	Description	
	Authorized by Beneficiary	Yes No
	Consumable Only:	
	Non-Consumables:	Supplies in good functional condition (remaining quantity): Replacement reason:

Refill Request (authorized by):	
Relationship with the Beneficiary (if applicable):	

This is a suggested Refill Request Form, The use of this form is optional. Please refer to the DME MAC Jurisdiction B Supplier Manual, Chapter 3 for a detailed description of documentation requirements regarding Refill Request: http://www.cgsmedicare.com/jb/pubs/pdf/chpt3.pdf

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES