



Provider Name

Address 1

Address 2

City ST 00000

**Date:** 1/1/1900  
**Reference ID:** CID #: 1555555  
**NPI/Provider #:** 0000000000  
**Phone:**  
**Fax:**

**Request Type & Purpose: First Letter**  
**Subject: Additional Documentation Required**

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.<sup>1</sup> The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit [www.cms.gov/CERT](http://www.cms.gov/CERT).

## Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

## Action: Medical Records Required

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the CERT program. **Providing medical records of Medicare patients to the CERT program does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified on the attached Bar Coded Cover Sheet. The CMS is not authorized to reimburse providers/suppliers for the cost of medical record duplication or mailing. If you use a photocopy service, please ensure that the service does not invoice the CERT program.

## When:1/1/1900

Please provide the requested documentation by 1/1/1900 . A response is still required by 1/1/1900 even if you are unable to locate the requested information.

## Consequences

If the provider/supplier fails to send the requested documentation or contact CMS by 1/1/1900 , the provider's/supplier's Medicare contractor will initiate claims adjustments or overpayment recoupment actions for these undocumented services.

<sup>1</sup>Social Security Act Sections 1833 [42 USC §1395l(e)] and 1815 [42 USC §1395g(a)]; 42 CFR 405.980-986



## Instructions

- Specific information and instructions pertaining to the sampled claim and returning requested documents are shown on the following pages of this letter.
- Please include the bar coded cover sheet with your submission.

## Submission Methods

You may submit this documentation in any of the following ways:

- Via postal mail to: CERT Documentation Center,  
1510 East Parham Road  
Henrico, VA 23228
- Via fax to: 804-261-8100
  - 1) Use the Barcoded coversheet as the only coversheet.
  - 2) Do not add your own coversheet—this slows down the receipt and identification process.
  - 3) Send a separate fax transmission for each individual claim.
- Via Electronic Submission of Medical Documentation (esMD):
  - 1) Include a CID# or Claim number and the barcoded cover sheet in your file transmission.
  - 2) Information on esMD can be found at [www.cms.gov/esMD](http://www.cms.gov/esMD).
- Via CD:
  - 1) The images should be encrypted per HIPAA security rules.
  - 2) If encrypted, the password and CID# must be provided via email to [CERTMail@admedcorp.com](mailto:CERTMail@admedcorp.com) or via fax to 804-264-9764.
  - 3) Must contain only images in TIFF or PDF format.
- Via Email Attachment:
  - 1) The email attachment(s) should be encrypted per HIPAA security rules.
  - 2) If encrypted, the password and CID# must be provided via phone to 888-779-7477 or via fax to 804-264-9764.
  - 3) Must contain only attachments in TIFF or PDF format.

## Questions

If you have any questions, please contact:

CERT Documentation Center  
1510 East Parham Road  
Henrico, VA 23228

Office: 443-663-2699 or Toll Free: 888-779-7477

Fax: 804-261-8100

Sincerely,



Chrissy Fowler  
Director, Payment Accuracy & Reporting Group  
Office of Financial Management  
Centers for Medicare & Medicaid Services

## Attachments / Supplementary Information

1. Claim Information
2. Bar Coded Cover Sheet



# Claim Information

**Due Date: 1/1/1900**

Medicare Part B Provider

NPI/Provider #:	0000000000	Request Date:	1/1/1900
Patient Name:	Patient Name		
Date of Birth:	1/1/1900	<b>Date(s) of Service:</b>	<b>1/1/1900 - 1/1/1900</b>
CERT Claim ID (CID):	1555555	Patient Identifier:	
Claim Date:	1/1/1900	Claim Control Number (CCN):	CCN0000000000
Ref/Ord Provider/NPI #:	Referring Name 0000000000		
Medical Record Number:	MRN0000000000000	Patient Account #:	PCN0000000000

**Diagnoses Codes**

<b>Code 1</b>	<b>Code 2</b>	<b>Code 3</b>	<b>Code 4</b>	<b>Code 5</b>	<b>Code 6</b>	<b>Code 7</b>	<b>Code 8</b>	<b>Code 9</b>	<b>Code 10</b>
1	2	3	4	5	6	7	8	9	10
<b>Code 11</b>	<b>Code 12</b>	<b>Code 13</b>	<b>Code 14</b>	<b>Code 15</b>	<b>Code 16</b>	<b>Code 17</b>	<b>Code 18</b>	<b>Code 19</b>	<b>Code 20</b>
11	12	13	14	15	16	17	18	19	20
<b>Code 21</b>	<b>Code 22</b>	<b>Code 23</b>	<b>Code 24</b>	<b>Code 25</b>					
21	22	23	24	25					

Line Item Date	Revenue Code	Performing Provider/NPI #	Provider Specialty	Diagnosis Code	HCPCS Code	HCPCS Modifier 1	HCPCS Modifier 2	HCPCS Modifier 3	HCPCS Modifier 4
5/1/2018		0000000000		00000	00000	11	22	33	
5/2/2018		0000000000		00000	00000	11	22	33	
5/3/2018		0000000000		00000	00000	11	22	33	
5/4/2018		0000000000		00000	00000	11	22	33	
5/5/2018		0000000000		00000	00000	11	22	33	



**PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD**

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**Medicare CERT Review Contractor  
GS-00F-263CA CERT**



**Due Date: 1/1/1900** Medicare Part B Provider  
Patient Name: Patient Name  
Claim Control Number: CCN0000000000  
Request Date: 1/1/1900 **Date(s) of Service: 1/1/1900 - 1/1/1900**  
NPI/Provider #: 0000000000 Universe Date: 1/1/1900  
Contractor: 99999 Contractor Type: B  
Patient Date of Birth: 1/1/1900  
Letter Sequence: First Letter

*Providers and suppliers are required to maintain documentation supporting the submission of Medicare claims and to submit this documentation upon request. The documents listed in the following chart may be needed to support Medicare payment of the claim with the date(s) of service specified above. Please provide all of the pertinent medical records/documentation and any additional documentation needed to support this claim. If any pertinent documentation is missing, incomplete, or requires explanation, please include this information in the comments section.*

**Documents that may be required**

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**CERT Documentation Center - Attn: CID # 1555555  
1510 East Parham Road, Henrico VA 23228  
FAX 804-261-8100 PH 888-779-7477 or 443-663-2699**