BURGER REHABILITATION SYSTEMS, INC.

ADR/Denial Registration Form - EMAIL COMPLETED IN FULL TO: AppealsDivision@BurgerRehab.com

Facility: _____ **Facility Phone** _____ **Facility Fax** _____ **Date** _____

Contact: _____ **Phone** _____ **Fax** _____ **Email** _____

HIC #: _____ **Patient Name** _____ **Dates of Service:** _____

Date of Request/Letter: _____ **Date Burger Notified** _____

Type of Denial or ADR:

_____ RAC (ADR)

_____ Part B

_____ Other (describe)

Denial Reason Code (if applicable): _____

Burger (**Denied**) Charges:	OT $ _____	PT $ _____	ST $ _____	Combined $ (PPS only) _____
Burger Billed Charges	OT $ _____	PT $ _____	ST $ _____	Combined $ (PPS only) _____
Facility (**Denied**) Charges	OT $ _____	PT $ _____	ST $ _____	Combined $ (PPS only) _____
Facility Billed Charges	OT $ _____	PT $ _____	ST $ _____	Combined $ (PPS only) _____

For all claims, please submit the following documents (from start of care through discharge) to Burger Regional Manager:

Check all documents submitted:

_____ Denial Notice (Determination Letter, Remittance Advice, On-Line Claim Summary)

_____ Copy of the Facility UB-92 or billing document utilized to bill Medicare/Insurance

_____ Copy of Burger Patient Invoice for the period of the denial

_____ All physician signed/dated orders for Part A claims (not just those pertaining to therapy)

_____ All physician signed/dated therapy orders for Part B claims

_____ Therapy Evaluation/Plan of Care (signed/dated by physician)

_____ Therapy Re-certification Form/Updated Plan of Care (signed/dated by physician)

_____ Therapy Services Billing Logs – Daily Treatment Records

_____ Therapy Weekly Summaries

_____ Therapy Narrative Progress Notes, if applicable

_____ Therapy Home Assessment, if applicable

_____ Nurses/Doctors Notes

_____ Dysphagia Medical Work-Up (Speech only, if applicable)

_____ Modified Barium Swallow Study (Speech only, if applicable)

_____ All MDS Assessments for Part A claims

_____ MDS Assessment(s) for Part B claims if such demonstrate(s) decline prior to treatment, or progress post treatment

_____ Facility Physician Certification and Re-certification Form (Part A Claims)

_____ Hospital records to support look back into hospital stay for 5 and 14 day MDS(s)

_____ Hospital Discharge Summary (for the Part A qualifying stay OR for the hospitalization prior to Part B admission)

_____ Medication Flow Sheets, Nutrition Information, Social Service Information and/or Lab Tests, if applicable

PLEASE NOTE: MEDICARE and Contract DEADLINES MUST BE MET TO INDEMNIFY CLAIMS

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