PERFORMANT

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Region [Region #] Recovery Audit Contractor (RAC)

Date: [*Request Date*]

[*Facility Point of Contact*]
[*Physician Practice Name*]
[*Street Address Line 1*]
[*Street Address Line 2*]
[*City, State ZIP*]

Re: [*Provider Name*] [*Provider NPI*]
Subject: Rescind Letter
Letter Request ID: [*Letter Request ID*]
Batch ID: [0000567890 – 1] Note: Batch number – letter sequence number

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) has retained Performant Recovery, Inc. (Performant) to carry out the Recovery Audit Contractor (RAC) program in Region (Select for Region 1) [1 which includes CT, IN, KY, MA, ME, MI, NH, NY, OH, RI, and VT] (Select for Region 2) [2 which includes AR, CO, IA, IL, KS, LA, MN, MO, MS, NE, NM, OK, TX, and WI] (Select for Region 5) [5 which is Nationwide]. The RAC program, mandated by Congress, is aimed at identifying Medicare improper payments.

This letter is to notify you that at this time Performant is rescinding the review of the claim(s) shown on the attached report.

Thank you for your cooperation in this matter. If you have any questions regarding this letter, please direct your inquiry to Customer Service at 1-866-201-0580.

Sincerely,

Performant
Region [Region #]
Recovery Audit Contractor
Enclosure

Rescind Report

Beneficiary Name	Beneficiary HICN/MBI	DOS From	DOS To	Claim Number	Patient Control Number	Case ID
[*Smith, John*]	[*1234567890A*]	[*1/6/2008*]	[*1/8/2008*]	[*1234567890*]	[*XY1234567NN*]	[*900012345677*]

Performant Recovery, Inc.
[Address 1]
[Address 2 (if necessary)]
[City, State, Zip]

866-201-0580 TOLL FREE
325-224-6710 FAX
www.performantrac.com