



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



PALMETTO GBA
A CELERIAN GROUP COMPANY



Religious Non-Medical Health Care Institution (RNHCI) Form Letter

ALL fields are REQUIRED.

Provider Information

Provider Number (PTAN):

Patient and Claim Information

Patient Name:

Medicare Beneficiary Identifier (MBI/HIC)

Claim Date(s) of Service

From: _____
____ / ____ / ____

To: _____
____ / ____ / ____

Claim Number (DCN):

To enable us to determine whether or not the care you rendered was excepted or non-excepted, please indicate which of the following statements are true by checking the appropriate box (es):

- The patient paid for the services out of pocket instead of requesting payment from Medicare
- The patient was unable to make his/her beliefs and wishes known before receiving the services you have billed
- The service was a vaccination
- The vaccination was required by a government jurisdiction
- None of the above statements apply

Instructions:

- This form letter is to be used in the event a claim receives Reason Code U5189 due to a patient's election to receive Religious Non-Medical Health Care.
- Please call 855-696-0705 if you have questions regarding Home Health and Hospice (HHH) services.

CL-HHH-A-4002



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