



Document Number FOD - 7003

## Requesting Copies of Paper Remittance Statements



### Requesting Copies of Paper Remittance Statements

Due to HIPAA privacy requirements, CSC can no longer send copies of remittance statements to Providers without written consent authorizing us to do so. For your convenience, the consent form on page 2 of this document may be printed out and sent to CSC.

To request a copy of a remittance statement the Provider must send the request in writing on the Provider's letterhead to:

Computer Sciences Corporation  
 Attention: Remittance Retrieval  
 PO Box 4605  
 Rensselaer, NY 12144

The request must include the following:

- Provider ID Number
- Provider address and telephone number
- Remittance statement number (if known)
- MMIS check date (if there is a check associated with the remittance)
- Indicate if original remittance was paper or electronic
- An original signature, in ink – no stamps, must be on all written requests and the signature must match one on the consent form file

If the Provider generally receives paper remittance statements and did not receive a remittance statement with their check, they must state that in their request. No fee is charged to the Provider if they did not receive the original paper remittance statement and if the replacement request is made within 60 days of receiving the check.

If the Provider is requesting a duplicate copy to replace a lost statement, there is a fee (see below).

If the Provider receives electronic remittances, the electronic remittance can be resent if requested within 4 cycles of the original issuance date by calling Provider Services at (800) 343-9000. After 4 cycles, electronic remittances are only available in paper format for a fee (see below).

**NOTE: Requests for replacement remittance statements are subject to a 25 cents per page fee with a \$5.00 minimum charge.**

Upon receipt of the request, Remittance Retrieval will check their file to see if we have a written consent form (for ongoing release, or limited-time release for the appropriate date range) on file. If the written consent form is not on file, Remittance Retrieval will send the Provider the consent form to complete. If Providers have questions about completing the consent form, they may contact the Call Center at (800) 343-9000.

When there is a charge involved, Remittance Retrieval will notify the Provider, in writing, of the number of pages in the remit and the total cost. **Do not send a check until you receive an invoice for the replacement remittance.** The statement will be mailed to the Provider upon receipt of a check or money order for the appropriate amount.

If you have any questions, please contact:  
 CSC Call Center: (800) 343-9000

Hours of Operation:

**For provider inquiries pertaining to non-pharmacy billing or claims, or provider enrollment:** Monday through Friday: 7:30 a.m. - 6:00 p.m., Eastern Time (excluding holidays)

**For provider inquiries pertaining to eligibility, service authorizations, DVS, and pharmacy claims:** Monday through Friday: 7:00 a.m. - 10:00 p.m., Eastern Time (excluding holidays) Weekends and Holidays: 8:30 a.m. - 5:30 p.m., Eastern Time

**CSC Remittance Retrieval**

PO Box 4605, Rensselaer, NY 12144

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PROVIDER ID: \_\_\_\_\_

Due to the Privacy rule mandated by HIPAA, we are unable to release records to anyone without written authorization. To give authorization, please complete this form and return it to our office.

I give Computer Sciences Corporation authorization to release information regarding my Remittance records to the individual(s) within my organization as listed below.

Please Print

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Please choose how long this authorization will be in effect by placing an X in one of the boxes.

One time only  Ongoing release  Limited-time release (from): \_\_\_\_\_ to \_\_\_\_\_

This signed statement will remain valid for the entire time you have chosen unless you inform us otherwise in writing. Contact us at the address above. If you intend this information to provide authorization for future requests, the individual(s) designated above must initiate these requests in writing.

**Signature of Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

If you have any questions regarding this form feel free to contact CSC Provider Services at (800)343-9000