

**Fax to: (508) 643-0141**

# Massachusetts Chapter American College of Cardiology

## Fax Form

Please print neatly or type. This form can be photocopied.

Physician/Clinic Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

Include the following in your fax:

- 1. Patient Status
- 2. Chief Complaint
- 3. Your coding/reimbursement questions
- 4. The information above

**AND**

If you have received a rejection, please attach a copy. If you have asked for a review or are involved in a peer review, audit or legal action, please let us know. If there is a dispute or question in your office over the diagnosis code(s) that would properly support the procedures, let us know the specifics along with the question(s).

**For patient confidentiality, always omit or block out the patient name and identification.**

Question: \_\_\_\_\_

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