DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REGIONAL OFFICE REQUEST FOR ADDITIONAL INFORMATION OR OTHER ACTION

DATE

TO *(Name of State Agency or Regional Office)*

NAME *(Provider or Supplier)*

FROM

ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

ADDRESS

☐ HOSPITAL ☐ ESRD FACILITY ☐ SNF ☐ OPT ☐ HHA ☐ PORT X-RAY ☐ INDEPENDENT LABORATORY ☐ RHC

Please secure the information or take other action as requested below. Use reverse side for reply. If the file is attached, please return it to the Regional Office after completion of your development or other action and fasten all new materials inside the folder. If an amended certification is necessary, please prepare.

REMARKS AND REFERENCES: SEE SOM _____ ROM _____.

ATTACHMENTS: ☐ RO PROVIDER/SUPPLIER FILE ☐ OTHER

FORM CMS-1666 (4-80)

REPLY TO REQUEST FOR ADDITIONAL INFORMATION OR OTHER ACTION

TO

ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

FROM *(Name and address of State Agency or Regional Office)*

IN RESPONSE TO THE REQUEST ON THE REVERSE SIDE, THE FOLLOWING INFORMATION IS SUBMITTED:

SIGNATURE OF STATE AGENCY OR REGIONAL OFFICE REPRESENTATIVE

TITLE	DATE OF TRANSMITTAL