



EVIDENCE & RESOLUTION

Medicare Conditional Payment Review Workbook

Distinguish Medicare correspondence, examine listed payments, assemble support for unrelated-item questions and track the formal recovery process.

WHAT THIS WORKBOOK HELPS YOU DO

01

Complete your program and
correspondence map

02

Complete your payment-line
review

03

Complete your submission and
decision log

An Original Medicare beneficiary or authorized helper handling accident-related recovery correspondence.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01 Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.

GUIDANCE / PAGES 03-06

- 02 Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.

EXAMPLES / PAGE 07

- 03 Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.

WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Identify the program and correspondence

Begin with the program named on the notice and the person or entity from whom recovery is sought. A health-plan statement, Medicare conditional payment letter and final demand are different documents. Do not assume every Medicare-related claim is managed through the same contractor or portal. Record the letter date, case reference and action requested, but keep full Medicare numbers out of general-purpose notes. If the notice concerns a different program, ask the identified plan or a qualified professional for its procedure rather than forcing it into this workbook.

Confirm who may speak for the beneficiary

Helping organize paperwork does not automatically allow someone to speak or make decisions for the beneficiary. CMS distinguishes proof of representation from consent to release information. Use the current official instructions to determine what is needed and where it must be sent. Keep a copy of any authorization and track whether it has been recognized for the case. Do not share account passwords as a substitute. If the beneficiary has died or authority is uncertain, seek advice about the proper representative before submitting instructions on someone else's behalf.

RELATED WORKING SHEETS

- Program and correspondence map
- Submission and decision log

Sources for this page: [1], [2], [3], [4]. See the linked source guide.



GUIDANCE 2

02

Understand the stage before acting

A conditional payment amount can change as additional related claims are identified. An interim list should not be treated as the final amount needed to close a case. Record whether each notice requests information, permits review of listed items, demands repayment, or explains a decision. Use the actual letter and current CMS process to identify the next step and deadline. The date an organizer opens the mail is not necessarily the date from which a deadline runs. If timing is uncertain, contact the identified office or counsel promptly.

Compare each listed item with the record

Review the payment listing one item at a time. Match dates of service, provider, available description and the accident-related condition against records you have. Do not assume that every charge after the accident is related, or that a charge with an unfamiliar code is unrelated. Put unclear items in a question category and request help interpreting them. Where there is a documented basis to question an item, identify the supporting record. Your worksheet organizes a review; it does not itself remove an item from Medicare's accounting.

Match each listed item to available records and leave unclear items marked as questions.



Sources for this page: [1], [2], [3], [4]. See the linked source guide.



GUIDANCE 3

03

Prepare a supported question or dispute

Follow the current process and the notice's instructions if an item appears unrelated. State precisely which entry you are questioning and why, and attach relevant support through the approved channel. Keep the wording factual and do not invent a medical explanation. Preserve the submission and receipt. A pending dispute is not an approved reduction, and an acknowledgment is not a decision. Continue tracking any separate requirements while the question is reviewed. Where the underlying release or diagnosis creates uncertainty, obtain professional advice before making a representation.

Track settlement information separately

A settlement, judgment or other payment may trigger additional reporting and recovery steps. Gather the signed documents, payment details and fee/cost records requested by the applicable process. Reconcile the figures with the actual agreement and closing statement rather than a preliminary offer or a gross-to-net estimate. Do not assume that a previous conditional amount will remain unchanged after settlement information is submitted. This workbook does not choose a special calculation option or tell you how to allocate settlement proceeds. Those questions may require legal or benefits advice.

RELATED WORKING SHEETS

- [Payment-line review](#)
- [Submission and decision log](#)

Sources for this page: [1], [2], [3], [4]. See the linked source guide.



GUIDANCE 4

04

Read the demand and review-rights notice

When a demand arrives, identify the stated amount, calculation, payment instructions, and any appeal or waiver information. A request for a waiver and an appeal are different routes; neither should be selected simply because it sounds easier. Record the actual deadlines and who will advise or act. Do not assume that asking a question pauses interest, collection or a response requirement. Keep payment decisions and any challenge coordinated with counsel or the responsible professional so that contradictory instructions are not sent from separate helpers.

Close only on documented evidence

Maintain the file until the relevant office has provided evidence of the result, such as a decision, adjusted amount, payment acknowledgment or closure notice appropriate to the case. Reconcile what was requested, what was decided, what was paid and what remains open. Keep correspondence and proof together. A zero balance on your own worksheet is not an official closure. Prepare a short summary that distinguishes completed actions from assumptions and identifies other plans or reimbursement claims outside this Original Medicare workflow.

RELATED WORKING SHEETS

- Demand and closure reconciliation
- Submission and decision log

Sources for this page: [1], [2], [3], [4]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 An interim figure

The beneficiary has an older conditional payment letter and a new settlement offer.

Next step: Verify the current case information and applicable settlement-reporting process.

Avoid. Treating the older figure as a guaranteed final deduction.

02 A disputed item

One listed service appears unrelated, but the description is unclear.

Next step: Gather the relevant record and ask for help identifying the item before stating a factual basis for review.

Avoid. Assuming an unfamiliar code proves an erroneous charge.



WORKSHEET 1

01

Program and correspondence map

Do not place full Medicare IDs or portal credentials here. Identify the actual stage from the letter.

Program/contractor

Case alias

Letter type/date

Recipient/debtor named

Requested action

Deadline/source

Authorized representative

Next owner

Related guidance: [Identify the program and correspondence](#)



WORKSHEET 2

02

Payment-line review

Use records to support questions and leave medical interpretation to qualified professionals.

Entry ID

Service date

Provider

Listed payment

Record reference

Related/questioned/unknown

Specific concern

Supporting exhibit

Decision received

Related guidance: [Prepare a supported question or dispute](#)



WORKSHEET 3

03

Submission and decision log

Receipt and approval are different milestones. Keep copies of both.

Issue

Submission method/date

Documents sent

Receipt

Response due/verified

Decision date

Amount changed

Unresolved issue

Related guidance: [Prepare a supported question or dispute](#)



WORKSHEET 4

04

Demand and closure reconciliation

Use the actual demand and professional advice for deadlines and payment decisions.

Demand date

Amount stated

Calculation questions

Appeal/waiver question

Assigned adviser

Verified deadlines

Payment reference if applicable

Official acknowledgment

Other recovery claims

Related guidance: [Read the demand and review-rights notice](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] CMS conditional payment information

CPLs, CPNs, payment-list review and reporting settlement information have distinct roles in recovery. Scope: Original Medicare recovery guidance; exact current notice controls the next required action.

<https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services/conditional-payment-information>

[2] CMS proof of representation and consent to release

Receiving information and acting as a representative require different authority. Scope: Use the current free official forms and instructions for the required permission or representation.

<https://www.cms.gov/medicare/coordination-benefits-recovery/attorney-services/proof-representation-consent-release>

[3] CMS reimbursing Medicare

Demand letters include repayment and appeal information; waiver and appeal are distinct. Scope: No predicted waiver eligibility or automatic pause in obligations.

<https://www.cms.gov/medicare/coordination-benefits-recovery/overview/reimbursing>



REFERENCE GUIDE

More source notes

[4] CMS Medicare Secondary Payer Recovery Portal

The official portal supports conditional-payment review, correspondence and settlement-information tasks. Scope: Portal access and available actions depend on the user's role and case.

<https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer-recovery-portal>

Keep the scope clear

No treating conditional amount as final

No advice to ignore demand or stop repayment