

## Medicare JE Part A Redetermination/Reopening Form

**Please submit one claim per Redetermination request form.**

**When to request a redetermination** – A redetermination should be requested when there is dissatisfaction with the original determination. A redetermination is the first level of the appeals process and is an independent re-examination of an initial claim determination. **A claim must be appealed within 120 days from the date of receipt of the initial Medicare Summary Notice (MSN), Remittance Advice (RA) or Overpayment Demand Letter.** Noridian has 60 days from the date of receipt to complete your request.

**Would you like to submit electronically?** Try the [Noridian Medicare Portal](#).

**State:**  CA  HI and Territories  NV

**Types of Request:**  Overpayment Redetermination  Comprehensive Error Rate Testing  Recovery Auditor  
 Redetermination  Supplemental Medical Review Contractor  Zone Program Integrity Contactor  
 Quality Improvement Organization

**Note:** When requesting an overpayment redetermination, please send a copy of the overpayment decision letter.

**\*Required Information** Redetermination requests with incomplete information will be dismissed. Please include a copy of the Remittance Advice and medical documentation.

**\*Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**\*Medicare Number:** \_\_\_\_\_ **Initial Determination or Overpayment Demand Letter Date:** \_\_\_\_\_

**\*Date(s) of Service:** \_\_\_\_\_

**\*HCPCS/Procedure Codes:** \_\_\_\_\_ **AR Number or OV Demand Letter Number:** \_\_\_\_\_

\_\_\_\_\_ **Billed Amount of the Code(s) to be Reviewed:** \_\_\_\_\_

**DCN:** \_\_\_\_\_ **Total Claim Billed Amount:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_ **Diagnosis of Services Appealed:** \_\_\_\_\_

**Provider Address:** \_\_\_\_\_ **Tax ID Number:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**PTAN Number:** \_\_\_\_\_ **Provider Email Address:** \_\_\_\_\_

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

**Action Request/Comments:**

**\*Requestor's Signature (Required):** \_\_\_\_\_

**Choosing the incorrect PO Box could cause a delay in the processing of the claim.** Please attach all supporting documentation, which may include the operative report, office notes, etc. Reasonable and necessary denials must include a copy of the ABN signed by the beneficiary, if applicable. Please select one of the following two options:

- Overpayment Redetermination**  
 (All Types of Overpayments)  
 Medicare Part A  
 Attn: Overpayment Redeterminations  
 PO Box 6784 Fargo, ND 58108-6784
- Redeterminations**  
 Medicare Part A  
 Attn: Redeterminations  
**PO Box**  
 Fargo, ND 58108-

State	Box Number & Zip Code Ext
CA	6770
HI and Territories	6773
NV	6772

**Fax appeal requests to: 701-277-7852**

**Print Form**