noridian
Healthcare Solutions

JE Enrollment Reconsideration (Appeal) Request Form

Must be received within 60 calendar days from date of the Notification Letter

Provider Name: _____ Reference Number: _____

NPI: _____ PTAN: _____ Contact Person: _____

Appeal Reason: Please provide details as to why this request is being submitted. (Billing privileges being revoked/denied, change of information request denial, reassignment denials and effective date determination for initial enrollments may be appealed)

If you require more space, please include additional information and/or all supporting documentation you feel would assist in processing your appeal. (I.E. Determination/notification letter, correspondence, etc)

Provider Signature: _____ Date _____

Type/Print Signatory Name: _____
Please select one of the boxes indicating the signer's role with the provider/supplier.

☐ Provider/Supplier ☐ Authorized or Delegated Official ☐ Legal Representative

*Note: This form must be printed and mailed with an original signature from the provider, authorized/delegated official or a legal representative of the provider. A signature from the contact on the application will not be accepted. Please mail request to the following address:

USPS:

Medicare Part B
Attn: Provider Enrollment
PO Box XXXX
Fargo, ND 58108-XXXX

FedEx/Ups:

Medicare Part B
Attn: Provider Enrollment
900 42nd St S
Fargo, ND 58103

Replace XXXX above with the PO Box and Zip Code Extension

State	PO Box/Zip Ext	State	PO Box/Zip Ext
N CA (CA)	6774	S CA (CB)	6775
NV	6776	HI	6777

*NOTE: Rejected and/or Returned Applications do not have appeal rights.
Please reference PIM Chapter 15.25

Print Form