

Medicare Part B JE Redetermination 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: AS N CA S CA GU HI MP NV

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

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:** _____

ICN: _____ **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 B
 Attn: Overpayment
 Redeterminations
 PO Box 6785 Fargo, ND 58108-6785
- Redeterminations**
 Medicare Part B
 Attn: Redeterminations
PO Box
 Fargo, ND 58108-

State	Box Number & Zip Code Ext
Hawaii, American Samoa, Guam, Northern Mariana Islands	6777
Nevada	6776
Northern California	6774
Southern California	6775

Fax appeal requests to: 701-277-7852

Print Form