NORIDIAN HEALTHCARE SOLUTIONS

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 ☐ Unified Program Integrity Contractor

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 of 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:** _____

Billing NPI: _____ **Fax Number:** _____

Billing PTAN: _____ **Provider Email Address:** _____

Contact Person: _____

Action Request/Comments:

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.

☐ **Redeterminations**
Medicare Part B
Attn: Redeterminations
PO Box 6774
Fargo, ND 58108-6774

Please take a moment to share your thoughts by scanning the QR code.

Fax appeal requests to: 701-277-7852

Print Form

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES