

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.

<p>*Patient Name: _____</p> <p>*Medicare Number: _____</p> <p>*Date(s) of Service: _____</p> <p>*HCPCS/Procedure Codes: _____</p> <p>_____</p> <p>ICN: _____</p> <p>Provider Name: _____</p> <p>Provider Address: _____</p> <p>City, State, Zip: _____</p> <p>Billing NPI: _____</p> <p>Billing PTAN: _____</p> <p>Contact Person: _____</p> <p>Action Request/Comments:</p>	<p>Date of Birth: _____</p> <p>Initial Determination or Overpayment Demand Letter Date: _____</p> <p>AR Number or OV Demand Letter Number: _____</p> <p>Billed Amount of the Code(s) to be Reviewed: _____</p> <p>Total Claim Billed Amount: _____</p> <p>Diagnosis of Services Appealed: _____</p> <p>Tax ID Number: _____</p> <p>Telephone Number: _____</p> <p>Fax Number: _____</p> <p>Provider Email Address: _____</p>
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Requestor's Signature: _____

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.

- 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

