

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 services were provided: ☐ AK ☐ AZ ☐ ID ☐ MT ☐ ND ☐ OR ☐ SD ☐ UT ☐ WA ☐ WY

Types of Request: ☐ Overpayment Redetermination ☐ Comprehensive Error Rate Testing ☐ Recovery Auditor
☐ Redetermination ☐ Supplemental Medical Review Contractor ☐ Unified Program Integrity Contractor
☐ 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: _____
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 A
Attn: Redeterminations
PO Box 6720
Fargo, ND 58108-6720

Fax appeal requests to: 701-277-7852

Print Form