noridian
Healthcare Solutions

# Medicare JF Part A Redetermination/Reopening 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 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:**
***Medicare Number:**
***Date(s) of Service:**
***HCPCS/Procedure Codes:**
**DCN:**
**Provider Name:**
**Provider Address:**
**City, State, Zip:**
**NPI Number:**
**PTAN Number:**
**Contact Person:**

**Date of Birth:**
**Initial Determination or Overpayment Demand Letter Date:**
**AR Number or OV Demand Letter Number:**
**Billed Amount of the Code(s) to be Reviewed:**
**Total Claim Billed Amount:**
**Diagnosis of Services Appealed:**
**Tax ID Number:**
**Telephone Number:**
**Fax Number:**
**Provider Email Address:**

**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 A
Attn: Overpayment Redeterminations
PO Box 6744 Fargo, ND 58108-6744

☐ **Redeterminations**
Medicare Part A
Attn: Redeterminations
**PO Box (Select One)**
Fargo, ND 58108- **(Select One)**

| State | Box Number & Zip Code Ext | State | Box Number & Zip Code Ext |
|---|---|---|---|
| AK | 6720 | AZ | 6730 |
| ID | 6726 | MT | 6732 |
| ND | 6709 | OR | 6726 |
| SD | 6733 | UT | 6724 |
| WA | 6720 | WY | 6734 |

**Fax appeal requests to: 701-277-7852**

Print Form

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