noridian
Healthcare Solutions

JF Enrollment Corrective Action Plan (CAP) Request Form

Must be received within 30 calendar days from date of the Notification Letter

Provider Name: _____ Reference Number: _____

NPI: _____ PTAN: _____ Contact Person: _____

CAP Reason: The Corrective Action Plan (CAP) process gives a provider/supplier an opportunity to correct deficiencies that resulted in billing privileges being denied or revoked by Provider Enrollment.

- **The CAP must also include a response in the form of a letter.**
- **This page can be used as a fax coversheet or can be mailed with your CAP letter.**
- The space below can be used to add direction or include additional information.

Please attach all supporting documentation you feel would assist in processing your CAP. (I.E. Denial/Revocation letter, correspondence, evidence showing compliance with Medicare Requirements, etc)

Provider Signature: _____ Date _____

Type/Print Signatory Name: _____
Please select one of the boxes indicating the signer's role with the provider/supplier.

☐ Provider/Supplier ☐ Authorized or Delegated Official ☐ Legal Representative

*Note: This form can be faxed to 1-701-277-7868 with an original signature from the provider, authorized/delegated official or a legal representative of the provider. A signature from the contact on the application will not be accepted. You may also mail this request to the following address:

USPS:

Medicare Part B
Attn: Provider Enrollment
PO Box XXXX
Fargo, ND 58108-XXXX

FedEx/Ups:

Medicare Part B
Attn: Provider Enrollment
900 42nd St S
Fargo, ND 58103

Replace XXXX above with the PO Box and Zip Code Extension

State	PO Box/Zip Ext	State	PO Box/Zip Ext
AK	6703	AZ	6704
ID	6701	MT	6735
ND	6706	OR	6702
SD	6707	UT	6725
WA	6700	WY	6708

Print Form