

JF Enrollment Reconsideration (Appeal) Request Form

Must be received within 60 calendar days from date of the Notification Letter

Provider Name: _____ Reference Number: _____

NPI: _____ PTAN: _____ Contact Person: _____

Appeal Reason: Please provide details as to why this request is being submitted. (Billing privileges being revoked/denied, change of information request denial, reassignment denials and effective date determination for initial enrollments may be appealed)

If you require more space, please include additional information and/or all supporting documentation you feel would assist in processing your appeal. (I.E. Determination/notification letter, correspondence, 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 must be printed and mailed 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. Please mail request to the following address:

USPS:

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

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 |

*NOTE: Rejected and/or Returned Applications do not have appeal rights. Please reference PIM Chapter 15.25

Print Form