PLEASE INCLUDE THIS COMPLETED FORM WITH THE SUBMISSION OF YOUR CORRECTIVE ACTION PLAN AND/OR RECONSIDERATION REQUEST

Improperly submitted requests may be dismissed

Provider/Supplier Name: _____

Provider/Supplier Address: _____

National Provider Identifier (NPI): _____ **PTAN:** _____
Provider/Supplier Email Address: _____
Provider/Supplier Fax Number: _____

Medicare Administrative Contractor: Noridian Healthcare Solutions, Jurisdiction JF Part B (MAC Appeal)

This appeal submission is based on a(n): ☐ **Denial** ☐ **Revocation** ☐ **Effective Date**

CHOOSE ALL THAT APPLY FROM THE FOLLOWING:
Be sure to indicate if you are submitting both a CAP and Reconsideration Request or either individually

I am submitting a –

☐ **Corrective Action Plan (CAP)** – *The CAP is an opportunity for the provider/supplier to correct the deficiencies (if possible) that resulted in the denial or revocation of billing privileges.* ***A CAP may only be submitted for denials under 42 C.F.R. § 424.530(a)(1) or revocation of billing privileges under 42 C.F.R. § 424.535(a)(1).***

When submitting a CAP, it must:

1. Contain verifiable evidence that the provider/supplier is in compliance with Medicare requirements;
2. Be submitted within 35 days from the date of the denial or revocation notice;
3. Be submitted in the form of a letter that is signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.
4. If a legal representative is an attorney, the CAP must also contain a statement that the attorney has the authority to act on behalf of the provider/supplier. If the legal representative is not an attorney, the CAP must contain written notice of the appointment of the non-attorney as legal representative signed by the provider, supplier, or authorized/delegated official.

A decision will be issued within 60 days of receipt of the CAP.

The time to submit a reconsideration request runs concurrently with the time to submit a CAP. For example, if a CAP is submitted 20 days after the initial determination, there are 40 days remaining to submit a reconsideration request. These 40 days continue to elapse while the CAP is under consideration. Please note that failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

☐ **Reconsideration Request –** *A reconsideration request is an opportunity for a provider/supplier to furnish evidence that demonstrates that there was an error made at the time of the initial determination affecting participation in the Medicare Program.*

When submitting a reconsideration request, it must:

1. State the issues, or the findings of fact with which you disagree, and the reasons for disagreement.
2. Be submitted within 65 days from the date of the initial determination;
3. Be submitted in the form of a letter that is signed and dated by the individual provider/supplier, the authorized or delegated official, or a legal representative.
4. If a legal representative is an attorney, the reconsideration request must also contain a statement that the attorney has the authority to act on behalf of the provider/supplier. If the legal representative is not an attorney, the reconsideration request must contain written notice of the

appointment of the non-attorney as legal representative signed by the provider, supplier, or authorized/delegated official.

A decision will be issued within 90 days of receipt of the reconsideration request.

Please mail, email, or fax this form, the CAP or reconsideration request letter (signed and dated by the valid submitter), the initial determination letter, and all supporting documentation applicable to the appeal to the following address:

MAC 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 Ext.

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

or MAC Email Address:
PEAppeals@noridian.com

or MAC Fax Number:
Medicare Part B: 701-277-7868