NORIDIAN HEALTHCARE SOLUTIONS

Medicare Part B JF Redetermination 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

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:**

ICN:

Provider Name:

Provider Address:

City, State, Zip:

Billing NPI

Billing PTAN:

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:

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.

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

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

Fax appeal requests to: 701-277-7852

Print Form

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

29317556 • 1-25