

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: _____ Date of Birth: _____

*Medicare Number: _____ Initial Determination or Overpayment Demand Letter Date: _____

*Date(s) of Service: _____

*HCPCS/Procedure Codes: _____ AR Number or OV Demand Letter Number: _____

_____ Billed Amount of the Code(s) to be Reviewed: _____

ICN: _____ Total Claim Billed Amount: _____

Provider Name: _____ Diagnosis of Services Appealed: _____

Provider Address: _____ Tax ID Number: _____

City, State, Zip: _____ Telephone Number: _____

NPI Number: _____ Fax Number: _____

PTAN Number: _____ Provider Email Address: _____

Contact Person: _____

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 B
 Attn: Overpayment
 Redeterminations
 PO Box 6745 Fargo, ND 58108-6745

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

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