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 ☐ Zone Program Integrity Contactor

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:
NPI Number:
PTAN Number:
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:

***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 (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

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