MEDICARE DME Redetermination Request Form

Supplier Information

Supplier Name ______________________

PTAN ______________ NPI ______________

Tax ID ______________________

Address ______________________

City ______________________

State ______________ Zip Code ______________

Phone Number ______________________

___ Jurisdiction A - Noridian Healthcare Solutions

___ Jurisdiction B - CGS Administrators, LLC

___ Jurisdiction C - CGS Administrators, LLC

___ Jurisdiction D - Noridian Healthcare Solutions

Beneficiary Information

Patient Name ______________________

Medicare Number ______________________

State ______________________

Phone Number ______________________

Requestor's Name/Supplier Contact Name ______________________

Requestor's Signature (required) ______________________ Date ______________

Overpayment Appeal __ Yes If yes, who requested overpayment: __ Medical Review __ ZPIC/UPIC __ SMRC __ CERT __ Recovery Auditor

Date of Service	HCPCS & Modifiers	CCN	Date of Initial Determination

Suggested Documentation Check List: ___ Medicare Remittance Advice ___ CMN/DIF/Physician's Written Order ___ ABN ___ Medical Documentation

Reasons/Rationale ______________________

Fax Numbers

Noridian Healthcare Solutions - JA 1-701-277-2425

CGS Administrators, LLC - JB 1-615-660-5976

CGS Administrators, LLC - JC 1-615-782-4630

Noridian Healthcare Solutions - JD 1-701-277-7886

June 21, 2017.

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