NORIDIAN
HEALTHCARE SOLUTIONS

Medicare DME Redetermination Request Form

Supplier Information

Supplier Name _____

PTAN _____

NPI _____

Tax ID _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

Supplier Email Address _____

Requestor's Name/Supplier Contact Name _____

☐ Jurisdiction A - Noridian Healthcare Solutions

☐ Jurisdiction D - Noridian Healthcare Solutions

Beneficiary Information

Beneficiary Name _____

Medicare Number _____

State _____

Phone Number _____

Overpayment Appeal

☐ YES — If yes, who requested overpayment:

☐ Medical Review ☐ UPIC ☐ SMRC ☐ CERT ☐ Recovery Auditor

Date of Service	HCPCS & Modifiers	CCN	Date of Initial Determination

Reasons/Rationale

Please attach all supporting documentation. This may include, but not limited to, a standard written order, refill request, relevant medical documentation and a copy of the beneficiary-signed ABN, if applicable.

Fax Numbers
Noridian Healthcare Solutions - JA 1-701-277-2425
Noridian Healthcare Solutions - JD 1-701-277-7886

Please take a moment to share your thoughts by scanning the QR code.

JA **JD**

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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