

**Supplier Information**

Supplier Name \_\_\_\_\_

PTAN \_\_\_\_\_

NPI \_\_\_\_\_

Tax ID \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Supplier Email Address \_\_\_\_\_

Requestor's Name/Supplier Contact Name \_\_\_\_\_

**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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Suggested Documentation Check List:**

Medicare Remittance Advice

ABN

**Reasons/Rationale**

CMN/DIF/Physician's Written Order

Medical Documentation

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



JA

JA



**Fax Numbers**

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

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