noridian
Healthcare Solutions

Medicare Pilot Program for Asbestos Related Disease Appeal Request Form

If you believe your claim was denied inappropriately, you may request an Appeal within 120 days of the date of the Explanation of Benefits (EOB) or Remittance Advice (RA).

To ensure your request is processed timely, include a copy of the EOB or RA and the following information:

Patient/Beneficiary First Name: _____ Patient/Beneficiary Last Name: _____

Medicare Number as shown on the Medicare Card: _____

Date Item or Service Received: ☐/☐/_____

Provider/Physician Name: _____
HCPCS/Procedure Code/Description of Service in Question:

_____

Requester's Name: _____

Note: If the requester is not the beneficiary or the provider, a CMS-1696 form, Appointment of Representative, must be completed and submitted with this appeal request. This form can be found at http://www.cms.gov/cmsforms/downloads/cms1696.pdf.

Requester's Telephone Number: (___) _____-_____

Requester's Relationship to the Beneficiary: _____

Reason you feel your claim should be covered:

_____

_____
Requester's Signature (Required)

Please attach all supporting documentation, which may include the operative report, office notes, etc. Reasonable and necessary denials must include a copy of the Advance Beneficiary Notice of Noncoverage (ABN) signed by the beneficiary, if applicable.

Mail to:
Medicare Pilot Program for Asbestos Related Disease
PO Box 6761
Fargo, ND 58108-6761

Fax to:
1-866-352-6158