

REDETERMINATION REQUEST FORM

COMPLETION GUIDE

DATA ELEMENT SPECIFIC INSTRUCTIONS

Form completion instructions are provided for each data item, which is indicated by a number. Please note that data items are in groups of related information.

MAIL COMPLETED FORM TO:

The Medicare Claims Processing Manual, Chapter 29 indicates that parties to a claim must file a request for redetermination with the proper contractor based on the claims processing jurisdiction rules established by the Medicare program. Jurisdiction for DMEPOS claims is established based on the state where the beneficiary resides.

Indicate the appropriate jurisdiction by checking the box to the left of the Jurisdiction name.

- Jurisdiction A – Noridian Healthcare Solutions
- **Jurisdiction B – CGS, Administrators, LLC**
- **Jurisdiction C – CGS, Administrators, LLC**
- Jurisdiction D – Noridian Healthcare Solutions

Jurisdiction B: CGS
PO Box 20007
Nashville, TN 37202

Jurisdiction C: CGS
PO Box 20009
Nashville, TN 37202

Suppliers are reminded that they also have the option of submitting requests for redetermination electronically. The fax numbers for each jurisdiction are provided in the bottom left hand corner of the Redetermination Request Form.

FAX NUMBERS:

- **Noridian Healthcare Solutions:** 1.701.277.7855
- **CGS Administrators, LLC:** 1.615.660.5976
- **CGS Administrators, LLC:** 1.615.782.4630
- **Noridian Healthcare Solutions:** 1.701.277.7886

SUPPLIER INFORMATION SECTION

1. **Name:** Enter the name of the company/supplier.
2. **Provider Transaction Access Number (PTAN)#:** Enter the 10-digit PTAN number assigned by the National Supplier Clearinghouse (NSC).
3. **National Provider Identifier (NPI):** Enter the 10-digit NPI number assigned by the National Plan & Provider Enumeration System (NPPES).
4. **Tax ID:** Enter the 9-digit Tax ID number assigned by the Internal Revenue Service.
5. **Address:** Enter the supplier's billing address.
6. **Phone #:** Enter the published phone number for the company.

BENEFICIARY INFORMATION SECTION

1. **Patient Name:** Enter the name of the patient (beneficiary) as it appears on their red, white and blue Medicare card.
2. **Medicare Number:** Enter the HICN of the patient (beneficiary) as it appears on their red, white and blue Medicare card.
3. **State:** Enter the patient's (beneficiary's) permanent state of residence on file with the Social Security Administration.

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4. **Phone Number:** Enter a contact number where the patient (beneficiary) may be reached if additional patient (beneficiary) information is required.

CONTACT INFORMATION FOR REQUESTOR SECTION

1. **Requestor's Name/Supplier Contact Name:** Print the first and last name of the individual requesting the Redetermination. Do not enter the company/supplier name. Indicate the name of the person that should be contacted if additional information is required.
2. **Requestor's Signature (required):** Enter the signature of the person requesting the Redetermination. The Centers for Medicare & Medicaid Service (CMS) Internet-only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 29, "Appeals of Claim Decisions", Section 310.64 indicates that a signature is a required element of the request for Redetermination. If a request for Redetermination is submitted and not signed the request for Redetermination will be dismissed.

OVERPAYMENT APPEAL SECTION

1. **Overpayment Appeal:** If the request for Redetermination is the result of an overpayment demand letter please indicate by checking the "Yes" box. Please indicate if the overpayment was identified by the DME MAC Medical Review Department, the Zone Program Integrity Contractor (ZPIC) or Program Safeguard Contractor (PSC), Comprehensive Error Rate Testing (CERT) Contractor, or Recovery Audit Contractor (RAC) by selecting the appropriate box.

CLAIM INFORMATION SECTION

1. **Date of Service:** Enter the specific date(s) of service in question.
2. **HCPCS & Modifiers:** Enter the specific HCPCS code(s) and modifier(s) for which the redetermination is being requested. (i.e., HCPCS & Modifiers indicated on the original claim determination).
3. **Claim Control Number (CCN):** Enter the 14-digit claim control number listed on your ERA/SPR for which the redetermination is being requested.
4. **Date of Initial Determination:** Enter the original date of determination listed on your Medicare Remittance Notice.

SUGGESTED DOCUMENTATION CHECKLIST

1. **Suggested Documentation Checklist:** Please indicate which documentation items are being submitted with the request for Redetermination by checking the applicable box. If you select medical documentation, please provide a description of the documentation (i.e., progress notes, lab results, etc.). Requests for Redetermination should include all pertinent medical documentation required to support the medical necessity for the item/service billed. The suggested documentation list is not an all-inclusive list and should be used as a guideline only. Failure to include all supporting documentation may result in a delay in processing the request for Redetermination or an unfavorable decision.

REASON/RATIONALE SECTION

1. **Reasons/Rationale:** Enter a detailed explanation of why you are requesting a Redetermination. While a detailed statement explaining the reason(s) for the Redetermination are essential, the statement must be supported by documentation.