MEDICARE Part A Jurisdiction 15 Redetermination Request Form

Provider Information

Provider Name:

PTAN: NPI:

Address:

City:

State: Zip Code:

Phone Number:

___ **OHIO - (15201)**

___ **KENTUCKY - (15101)**

Beneficiary Information

Patient Name:

Medicare Number:

Requestor's Name/Provider Contact Name:

Requestor's Signature: Signature must be hand-written

Overpayment Appeal: If yes, then check: ___ MR ___ ZPIC ___ CERT ___ RAC ___ Other

Date of Service:	Date of Initial Determination:	DCN:	Denied Services:

Note: Only one claim number per form should be submitted. Multiple claims per submission will not be acknowledged for processing.

Suggested Documentation Checklist:

___ Medicare Remittance Advice
___ Advance Beneficiary Notice
___ Physician's Written Order
___ Signed Medical Documentation

Reasons/Rationale:

CGS
Attn: J15 Part A Appeals Department
PO Box 20006
Nashville, TN 37202
Fax: 1-803-462-2585

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CGS℠
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