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 B – CGS, Administrators, LLC**
- **Jurisdiction C – CGS, Administrators, LLC**

Jurisdiction B:
CGS
PO Box 20007
Nashville, TN 37202
Fax: 1.615.660.5976

Jurisdiction C:
CGS
PO Box 20009
Nashville, TN 37202
Fax: 1.615.782.4630

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.

SUPPLIER INFORMATION SECTION

1. **Name of person appealing:** Print the first and last name of the individual requesting the Redetermination. Indicate the name of the person that should be contacted if additional information is required.
2. **Supplier Name:** Enter the name registered with the PTAN (Provider Transaction Access Number).
3. **Supplier address:** Enter the supplier's billing address.
4. **Person appealing's phone number:** Indicate the phone number of the person that should be contacted if additional information is required.
5. **Address:** Enter the supplier's billing address.
6. **Phone #:** Person appealing's phone number. Indicate the phone number of the person that should be contacted if additional information is required.
7. **PTAN:** Enter the 10-digit PTAN number assigned by the National Supplier Clearinghouse (NSC).

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 Medicare Number of the patient (beneficiary) as it appears on their red, white, and blue Medicare card.

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OVERPAYMENT APPEAL SECTION

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 (UPIC) or Program Safeguard Contractor (PSC), Comprehensive Error Rate Testing (CERT) Contractor, Recovery Audit Contractor (RAC), or Specialty Medical Review Contractor (SMRC) 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.

SUGGESTED DOCUMENTATION CHECKLIST SECTION

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

Reason/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.

LATE TIMELY FILING SECTION

Enter a detailed explanation as to why you were not able to submit within 120 days, include any documentation that may support.