

MEDICARE DME Redetermination Request Form

Supplier Information

Supplier Name _____

PTAN _____ NPI _____

Tax ID _____

Address _____

City _____

State _____ Zip Code _____

Phone Number _____

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

Beneficiary Information

Patient Name _____

Medicare Number _____

State _____

Phone Number _____

Requestor's Name/Supplier Contact Name _____

Overpayment Appeal YES If yes, who requested overpayment: Medical Review ZPIC/UPIC SMRC
 CERT Recovery Auditor

Date of Service	HCPCS & Modifiers	CCN	Date of Initial Determination
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Suggested Documentation Check List: Medicare Remittance Advice CMN/DIF/Physician's Written Order
 ABN Medical Documentation

Reasons/Rationale _____

Fax Numbers

- Noridian Healthcare Solutions - JA 1-701-277-2425
- CGS Administrators, LLC - JB 1-615-660-5976
- CGS Administrators, LLC - JC 1-615-782-4630
- Noridian Healthcare Solutions - JD 1-701-277-7886

