MEDICARE Part B Jurisdiction 15 Redetermination Request Form

Provider Information

Provider Name:

PTAN: NPI:

Tax ID:

Address:

City:

State: Zip Code:

Phone Number:

OHIO - (15202)

KENTUCKY - (15102)

Beneficiary Information

Patient Name:

Medicare Number:

State:

Phone Number:

Requestor's Name/Provider Contact Name:

Requestor's Signature: ***Signature not required as of July 8, 2019!***

Overpayment Appeal: If yes, then check: MR PROBE ZPIC/PSC CERT RAC Other

Date(s) of Service:	Denied CPT/HCPCS & Modifiers	Initial ICN (if overpayment, use the overpayment ICN:	Date of Initial Determination:

Suggested Documentation Checklist: Medicare Remittance Advice | Advance Beneficiary Notice | Physician's Written Order | Signed Medical Documentation

Reasons/Rationale:

CGS
Attn: J15 Part B Appeals Department
PO Box 20018
Nashville, TN 37202

Revised June 24, 2019.

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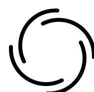

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