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:

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

Date of Service:	Denied CPT/ HCPCS & Modifiers	Initial claim 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

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