

MEDICARE Part B Reopening Request Form

A CMS Medicare Administrative Contractor

Select the state where services were provided:

Jurisdiction K: CT MA ME NH NY RI VT
 Jurisdiction 6: IL MN WI

Provider Information

Name: _____
 Address: _____
 PTAN: _____ NPI: _____
 Tax ID: _____

Claim Information

Date(s) of Service: _____
 Procedure Code(s): _____
 Internal Control Number: _____
 Bill Amount: _____
 Overpayment Amount: _____

Beneficiary Information

Name: _____ Date of Birth: _____
 MBI: _____

Type of Clerical Reopening

<p>Billing or Clerical Errors (Changes)</p> <p><input type="checkbox"/> Procedure code <input type="checkbox"/> Units of service <input type="checkbox"/> Modifier <input type="checkbox"/> Date of service <input type="checkbox"/> Place of service <input type="checkbox"/> Diagnosis code <input type="checkbox"/> Billed amount</p> <p><input type="checkbox"/> Rendering practitioner NPI <input type="checkbox"/> Incorrect fee schedule amount <input type="checkbox"/> Duplicate services (indicate total services rendered) <input type="checkbox"/> Service not related to automobile, no-fault, or liability insurance claim <input type="checkbox"/> Other (explain below)</p>	<p>Billed in Error</p> <p><input type="checkbox"/> Not our patient(s) <input type="checkbox"/> Services Not Rendered <input type="checkbox"/> Veteran Administration (VA) <input type="checkbox"/> Uniform Services Family Health Plan (USFHP) <input type="checkbox"/> Patient Enroll Health Maintenance Organization (HMO)</p> <p>Note: Services should not have been billed to the Medicare Program</p>
<p>Explain the needed correction below:</p> <div style="border: 1px solid black; height: 40px;"></div>	

General Information

- For automatic immediate recoupments for all and future overpayments, go to the [NGSMedicare.com website](http://NGSMedicare.com) > Overpayment > Request Immediate Recoupment > Immediate Recoupment Request Form – Electronic/E-mail
- Claims with modifier 22, 23, 52, 53, 62, 66, GA, GY or GZ should be submitted on the Redetermination Request Form with supporting documentation
- For multiple claims that contain the same issue, please include the LVAM form with this Part B Reopening Request Form

Requester Information

Printed Name: _____ Telephone Number: _____
 Signature: _____ Date Signed: _____

Mail to:

JK: National Government Services, Inc.
 P.O. Box 7111
 Indianapolis, IN 46207-7111

J6: National Government Services, Inc.
 P.O. Box 6475
 Indianapolis, IN 46207-6475

The legal authority for the collection of information on this form is authorized by Section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your claim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the Centers for Medicare & Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.