A CMS Medicare Administrative Contractor

MEDICARE
Part B Redetermination Request Form – Level 1

DO NOT use this form to notify us of overpayments including Medicare Secondary Payer (MSP) overpayments

Save time and money, consider using NGSConnex instead.

Please complete and mail this form with all pertinent documentation (medical records, certificate of medical necessity, operative notes, Advance Beneficiary Notice of Noncoverage, etc.). An * denotes a required field.

Select the state where services were provided:

Jurisdiction K: ☐ CT ☐ MA ☐ ME ☐ NH ☐ NY ☐ RI ☐ VT

Jurisdiction 6: ☐ IL ☐ MN ☐ WI

Provider Information	**Beneficiary Information**
*Name: ______	*Name: ______
Address: ______	*Medicare Number: ______
______	Date of Birth: ______
*PTAN: ______	
*NPI: ______	
TAX ID: ______	

Claim Information

*Date of Service: From: ______ To: ______ *Procedure Code: ______

Internal Control Number (ICN): ______ Billed Amount: ______

Are you appealing an overpayment requested by National Government Services? ☐ Yes ☐ No

Provide the AR Number or Letter Number (if available): ______

*__Reason for disagreement with the initial determination:__

☐ Denied as a Duplicate Incorrectly ☐ Timely Filing (explain delay in filing)

☐ Medical Necessity

☐ Other: ______

______

______

Note: *This form may be used for multiple claims that all contain the same issue. Attach a copy of the RA and indicate which claims should be corrected.*

Requester Information

*Printed Name: ______ *Signature: ______

Telephone Number: ______ 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 46206-6475