national government SERVICES

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 Beneficiary Identifier:_____
_____	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 6178
Indianapolis, IN 46207-6178

J6: National Government Services, Inc.
P.O. Box 6475
Indianapolis, IN 46206-6475

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES