National Government Services

A CMS Medicare Administrative Contractor

MEDICARE

Provider Enrollment Corrective Action Plan Form

Provider Name: _____ National Provider Identifier (NPI): _____

Address: _____ Email Address: _____

Suite, room, etc.: _____

City: _____ State: _____ Zip + 4: _____

Case Reference: _____ Provider Transaction Access Number(s) (PTAN): _____

Reason for Appeal: State of Enrollment: _____

◯ Revocation ◯ Enrollment Denial

Summary of Appeal:

Please include additional pages and any supporting documentation to support your summary as needed.

Provider Signature: _____ Date: _____

Print Name: _____ Role: _____

Note: The appeal request may only be signed by provider/supplier, authorized/delegated official or legal representative. A contact person does not qualify as a "legal representative" for purposes of signing the request.

A completed CAP form is required for each individual or entity. Please include additional pages and any supporting documentation to support your summary as needed.

Please mail this request within *30 days* from the date on the determination letter to:

J6 Part B

NGS Medicare
P.O. Box 6475
Indianapolis, IN 46206-6475
Fax: 317-595-4774

JK Part B

NGS Medicare
P.O. Box 7149
Indianapolis, IN 46206-7149
Fax: 315-442-4234

Overnight

NGS Medicare
8115 Knue Road
Indianapolis, IN 46206

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES