



A CMS Medicare Administrative Contractor

Medicare Part A Clerical Error/Omission Reopening Request Form

Note: Misrepresentation or falsifying essential information requested by this form may, upon conviction, be subject to fine or imprisonment under federal law.

Beneficiary's name: _____

Medicare number: _____

Date of the initial determination notice: _____

Date of service: _____

The provider requests to change the following clerical error/omission:

- From a diagnostic test to a screening test
From a screening test to a diagnostic test
From HCPCS _____ to HCPCS _____ because a number was transposed
From diagnosis code _____ to diagnosis code _____ because a number was transposed
Other: _____

Remember to attach supporting documentation.

Requester's Name (please print): _____

Requester's Address: _____

NPI: _____

PTAN: _____

Tax ID: _____

Requester's Relationship to the Beneficiary: _____

Requester's Telephone Number: _____

Requester's Signature: _____

Date Signed: _____

Mail Completed Form to:

Table with 3 columns: Jurisdiction K (Part A & HH+H-States), Jurisdiction 6 (Part A & HH+H-States), and FQHC - All States. Each column lists the National Government Services, Inc. Appeals Department address for that jurisdiction.

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.

