National Government Services

A CMS Medicare Administrative Contractor

MEDICARE

Provider Enrollment Reconsideration 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): ______________

State of Enrollment: ______________

Reason for Appeal:

Revocation   Enrollment Denial   Effective Date

Summary of Appeal:

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

Provider Signature: ______________________________ Date: ______________

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. An invalid signature will result in the closure of the reconsideration request.

Print Name: ______________________________ Role: ______________

Please mail this request within *60 days* from the date on the determination letter to:

J6 Part B

NGS Medicare
P.O. Box 6475
Indianapolis, IN 46206-6475

JK Part B

NGS Medicare
P.O. Box 7149
Indianapolis, IN 46206-7149

Overnight

NGS Medicare
8115 Knue Road
Indianapolis, IN 46206

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES