

U.S. Virgin Islands overpayment redetermination request form -- instructions

The following "Request for Overpayment Redetermination of a Medicare Part B Claim" form simplifies and standardizes filing requirements for redeterminations.

- The overpayment redetermination form allows the provider of services to clearly specify the reason(s) he or she disagrees with the overpayment determination (section 6).
- The form also provides space for a comprehensive and detailed explanation of any additional information that should be considered when the overpayment is reviewed (section 8).

Completion of these two sections is critical to correct processing of your overpayment redetermination request. Using this form will make handling requests for overpayment redeterminations easier and more efficient for providers' offices.

If all related information (dates of service, procedure codes, etc.) is filled in on the form as requested, copying and mailing of additional medical records may be significantly reduced (the current requirements for documentation for certain redetermination types have not changed).

Follow the instructions on the reverse side of the form and submit your request to the address indicated in section 1.

Note: Complete the overpayment redetermination request for a Medicare Part B claim form if you are disputing an existing overpayment. If First Coast Service Options Inc. (First Coast) has not sent a demand letter requesting a refund of payment and you are notifying First Coast of an overpayment, do not submit an overpayment redetermination request form. You must complete the overpayment refund form.

Overpayment Redetermination Request for a Medicare Part B Claim

NOTICE - Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

Print legibly and complete all information.

① **Carrier's Name and Address** JN Redeterminations, Inquiries, General Correspondence, Congressional VI Part A/B
P.O. Box 3412
Mechanicsburg, PA 17055-1851

② **Name of Patient**

③ **Patient's Medicare ID**

④ **Accounts Receivable Number**

⑤ **Please list all ICNs involved in the appeal request for the listed account receivable**

(If multiple ICNs indicate "multiple" and attach a list to this request).

⑥ **The reason(s) I disagree with the determination is/are:** (Please check those that apply)

☐ Service/claim underpaid/reduced ☐ Service/claim overpaid
☐ Duplicate ☐ Service(s) overutilized and/or not medically necessary
☐ OTHER: (Please be specific) _____

⑦ **For services in question, please provide:**

Date(s) of Service:	Quantity Billed:	Modifier:	Procedure Code:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

⑧ **Additional information to consider including specific diagnosis, illness and/or condition:**

⑨ **Attachments to consider:** (Please check all that apply)

☐ Medical records ☐ Copy of claim
☐ Ambulance run sheet ☐ Certificate of Medical Necessity
☐ Office records/progress notes
☐ OTHER: (Please be specific) _____

⑩ **Name of Claimant or Representative:**

Telephone Number:

You may provide a cover letter or attachments for multiple redetermination cases
PLEASE REFER TO THE BACK FOR AN EXPLANATION ON COMPLETING THIS FORM. Rev. 9/20

**Instructions for Completing the
Overpayment Redetermination Request Form**

Block ① - Carrier's Name and Address

All requests for redetermination of Medicare Part 'B' Claims should be mailed to address indicated in this block.

Block ② - Name of Patient

Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

Block ③ - Medicare ID

Enter the patient's Medicare ID as shown on the patient's Medicare card.

Block ④ - Indicate the 13-digit accounts receivable number

This number can be found on the header of the overpayment request letter or at the top of the Health Data Insight Request form. For letters dated on or after March 14, 2011, use the invoice number on the attachment of the letter.

Block ⑤ - I do not agree with the determination you made on ICN(s):

Indicate the 13 digit Internal Control Number (ICN) assigned to the claim submitted for reimbursement. This number can be found on the Provider Claim Summary (PCS), Provider Remittance Notice (PRN) or Medicare Summary Notice (MSN). Attach all ICNs involved in the appeal request for the accounts receivable.

Block ⑥ - The reason(s) I disagree with the determination is/are:

Check appropriate item(s) why you disagree with the decision made on the claim being submitted for redetermination. If **OTHER** is checked, please provide specific information.

Block ⑦ - For services in question, please provide:

Please indicate on each line the date(s) of service and procedure code that you are requesting be reviewed. A consecutive date range may be used per line; however, it should be for only one procedure code.

➤➤ Example of this would be: 01/01/2017 - 01/12/2017 99232 <<

Block ⑧ - Additional information to consider including specific diagnosis, illness and/or condition:

Provide any additional information that was not **originally** provided when the claim was submitted for processing.

Block ⑨ - Attachments to consider:

Check which attachments are being included with this form for consideration with the review of the claim being appealed.

Block ⑩ - Name of Claimant or Representative:

Name of claimant or representative and telephone number.

Reminder ☞ You may provide a cover letter or attachments for multiple redetermination cases.
To expedite your request, include all ICNs being appealed for each AR.