



52005



Medicare Part A Redetermination and Clerical Error Reopening Request Form

Submit Request via Fax: 904-361-0593

If this request is due to a Prior-Authorization denial select from the drop down: _____

Please select one of the following jurisdictions and check YES or NO to the questions below: _____

- 1. Are you requesting a Part A redetermination? _____
- 2. Are you requesting a Part A Overpayment redetermination? _____
- 3. Are you requesting a Part B of A redetermination? _____
- 4. Are you requesting a Part B of A Overpayment redetermination? _____
- 5. Are you requesting a Part A reopening (attach revised UB-04 form)? _____

The following criteria must be completed in all UPPERCASE letters:

Provider Transaction Access No (PTAN): Provider Name:

Provider Address:

Beneficiary Medicare Number (11 digits): Beneficiary Name:

DCN Document Control Number: NPI: Tax Identification No (last 5 digits):

*Date(s) Of Service:

*Requestor's Name (printed): Requestor Relationship To Appellant:

Telephone Number and Extension:

Please include a copy of your remittance advice notice.

7. Description of services being appealed	8. Date of service *		9. Amount of services at Issue (\$ in dispute)
	From	To	
a.			
b.			
c.			

The reason that I do not agree with the determination made is as follow:

