National Government Services

A CMS Contracted Agent

Medicare

Medicare Part B Appeals Request Form

This form may be used for one or more claims concerning the same issue. If your request involves multiple claims, you may attach a copy of your remittance advice to this form and place a star next to the services you want reviewed.

Please complete and mail this form with all pertinent documentation (e.g., Certificate of Medical Necessity, operative notes, test results, etc.) to the address below:

Jurisdiction K providers mail to:

National Government Services, Inc.
P.O. Box 7111
Indianapolis, IN 46207-7111

Jurisdiction 6 providers mail to:

National Government Services, Inc.
P.O. Box 6475
Indianapolis, IN 46206-6475

Claim Information

***Note:** For specific requirements for an appeal, please refer to **Review Process > Appeals** section of the http://www.NGSMedicare.com Web site.

Date of Request: _____ * **Beneficiary HICN:** _____
PTAN Number: _____ * **Beneficiary Name:** _____
TIN: _____ **NPI:** _____ **Beneficiary Date of Birth**: _____
Provider Name and Address: _____ **Beneficiary Address**: _____
_____ _____
_____ _____
Internal Control Number(s): _____ * **Procedure Code(s):** _____
* **Date(s) of Service:** _____ **Billed Amount:** _____

Request for: ❑ Redetermination ❑ Reopening

The date of the remittance advice for the claim in question: _____

Is Medicare Primary? ❑ Yes ❑ No

If the appeal concerns Medicare secondary payment, please indicate if you participate with the primary insurance company. ❑ Participate ❑ Do not participate

Reason for appeal/inquiry (and late filing explanation if applicable): _____
_____
_____

- If your request has exceeded the time limit for an appeal, please include the reason for late filing with your request.
- If requesting an appeal of an unassigned claim, as the beneficiary's representative, complete the Appointment of Representative Form (CMS-1696-U4). Otherwise, requests on behalf of the beneficiary can be made through this form or any written statement; however, the outcome of the appeal will only be disclosed to the beneficiary.

* **Requester's Name and Title:** _____ **Telephone Number:** _____
_____ **Date Signed:** _____
_____

* **Requester's Signature:** _____

CMS CENTERS for MEDICARE & MEDICAID SERVICES