FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

U.S. Virgin Islands

Form revised 11/17/2017

REQUEST FOR A REDETERMINATION/REOPENING OF *PART A* MEDICARE CLAIM

(Note: This is for an appeal and not to be used when requesting a claim adjustment)

Submit requests to:

First Coast Service Options, Inc.
Medicare Part A Appeals
P.O. Box 45097
Jacksonville, FL 32232-5097

☐ **Part A Redetermination (Inpatient SNF, IRF, IPF)**

☐ Part A Overpayment Redetermination *

☐ **Part B of A Redetermination (outpatient hosp, SNF, therapy)**

☐ Part B of A Overpayment Redetermination *

☐ **Part A Reopening (attach form UB-04)**

1. **Providers Name and Number ***

Address

City **State** **ZIP Code**

2. **Beneficiary's Name ***

Address

City State ZIP Code

3. **Medicare ID Number of the Patient***

4. The reason that I do not agree with the determination made is as follows:

5. **Document Control Number**

6. Please accept this as a request for an appeal for payment on the services which are indicated on this form.

Print Name

Telephone Number

Address

Signature *

City State ZIP Code

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

The request must be submitted within 120 days of the initial or revised initial denial date.
Please include documentation to support the service(s) at issue.
* If you have not received a demand letter requesting a refund of payment and you are notifying First Coast Service Options of an overpayment, you must complete the overpayment refund form.

Print Reset