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.

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**

Medicare Part B Overpayment Review
P. O. Box 45248
Jacksonville, Florida 32232-5248

② **Name of Patient**

③ **Patient's Medicare ID Number**

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 **Signature of Claimant or Representative:**
(Print) ____________________
(Written) ____________________

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. 4/2018

Form 23699-208

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 Identification Number 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.

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 - *Signature of Claimant or Representative:*

Signature of claimant or his 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.