

Highmark Medicare Services

MEDICARE PART A

REDETERMINATION REQUEST FORM

The request must be submitted within 120 days of the date the claim finalized.

- Part A Redetermination (e.g., Inpt Hospital, Inpt SNF, Inpt Rehabilitation Facility, Inpt Psychiatric Facility)
 Part B of A Redetermination (e.g., Outpt Hospital, Outpt SNF, CORF, ESRD, Rural Health Center, Inpt Part B only)

1. Beneficiary's Name:		2. Beneficiary's Medicare Number:	
3. Document Control Number of the Initial Claim:		4. Date of Initial Determination Notice:	
5. Description of Service(s) Appealed OR Attach a UB-04 CMS-1450 Claim Form and Circle the Appealed Services in lieu of completing this section.	6. Date(s) of Service From	To	7. Charge(s)
8. For claims with multiple denied HCPCS codes, please indicate the code(s) that apply to this request: <input type="checkbox"/> I am disputing ALL denied HCPCS code(s) and related service(s). <input type="checkbox"/> I am disputing the following HCPCS code(s) [please list each]:			
9. Additional Information Medicare Should Consider:			
10. Note: It is the provider's responsibility to submit any evidence that supports coverage of the service(s). <input type="checkbox"/> I have evidence to submit. (Attach to this Form). <input type="checkbox"/> I do not have evidence to submit.			
Please accept this as a request for an appeal for payment of the services indicated.			
11. Provider Name:		12. National Provider Identifier (NPI):	
13. Provider Address:		14. Requester's Telephone Number:	
15. Requester's Name (REQUIRED):		16. Requester's Signature (REQUIRED):	
17. Requester's Relationship to Provider/Beneficiary:		18. Date Signed:	

Mail to:

Pennsylvania	Maryland & District of Columbia	New Jersey
Highmark Medicare Services Attn: Part A Appeals Dept. P. O. Box 890385 Camp Hill, PA 17089-0385	Highmark Medicare Services Attn: Part A Appeals Dept. P. O. Box 890386 Camp Hill, PA 17089-0386	Highmark Medicare Services Attn: Part A Appeals Dept. P. O. Box 890420 Camp Hill, PA 17089-0420