REDETERMINATION: 1ST LEVEL APPEAL

Instructions:
Please type all fields. Fields with a red border are required.

PROVIDER INFORMATION

Provider Name

Provider Address

Provider Telephone & Extension

( ) - x

National Provider Identifier (NPI)

Provider Number (PTAN)

Provider Tax Identification Number (TIN)

REQUESTER INFORMATION (IF DIFFERENT)

Requester Name

Requester Address

Requester Telephone & Extension

( ) - x

PATIENT & CLAIM INFORMATION

Patient Name

Medicare Beneficiary Identifier (MBI/HIC)

Claim Number (DCN)

Claim Date(s) of Service

From To

-

REASON FOR APPEAL

REASON REQUEST SUBMISSION IS LATE (120 DAYS AFTER INITIAL DETERMINATION)

SUBMITTER INFORMATION

Name (Please Print)

Date

Please attach and include:

1. Please complete this form in its entirety.
2. Please complete only one form per beneficiary
3. You must include documentation to support your appeal. Examples include:
   - Medical Records for the dates of service appealed
   - Office records and progress notes
   - Treatment plan or plan of care
   - Physician's Orders
   - Certification or re-certifications for dates of services
   - Required assessment records (e.g. MDS, OASIS, PAI)

Please sign and submit this form with all additional documentation to:
Palmetto GBA Medicare HHH Appeals Department
Palmetto GBA
P.O. Box 100238
Columbia, SC 29202-3238