



REDETERMINATION: RECOVERY AUDIT CONTRACTOR (RAC)

Instructions

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

PROVIDER INFORMATION Provider Name	REQUESTER INFORMATION (IF DIFFERENT) Requester Name				PATIENT & CLAIM INFORMATION Patient Name	
Provider Address	Requester Address				Medicare Beneficiary Identifier (MBI/HIC)	
					Claim Number (DCN)	
Provider Telephone & Extension	Requester Telephone & Extension					
() - x National Provider Identifier (NPI)	()	-	х	Claim Date(s) of Service From	То
Provider Number (PTAN)					FCN / AR#	
Provider Tax Identification Number (TIN)						
REASON FOR APPEAL						

SUBMITTER INFORMATION

Name (Please Print) Date

Please attach and include:

- 1. A copy of the overpayment demand letter.
- 2. Please complete this form in its entirety.
- 3. Please complete only one form per beneficiary
- 4. 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

AP-HHH-A-1030 Rev: 08/17/2020