REDETERMINATION: COMPREHENSIVE ERROR RATE TESTING (CERT)

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

PROVIDER INFORMATION

CERT CID

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

-

FCN / AR#

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