PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Redetermination: 1st Level Appeal

***ALL** fields are **REQUIRED**.*

Select the region in which the services were provided:

☐ Alabama	☐ Georgia	☐ Tennessee

Provider Information

Provider Name:

Provider Address:

Provider Telephone Number:
( ) -

National Provider Identifier (NPI):

Provider Number (PTAN):

Tax ID:

Requestor Information (if different)

Requestor Name:

Requestor Address:

Requestor Telephone Number:
( ) -

Patient & Claim Information

Patient Name:

Medicare Beneficiary Identifier (MBI/HIC)

Claim Number (ICN):

Claim Date(s) of Service:

CPT Codes Being Appealed:

Diagnosis Code:

Reason for Appeal:

Name (Please Print):

Date:

PLEASE ATTACH:

1. Please complete this form in its entirety.
2. Please include the Remittance Advice (RA).
3. If you have multiple claims for the same issue, only one request (form) is needed for all, provided you attach the Remittance Advice (RA) and clearly indicate (circle or asterisk) which claims need to be reviewed.
4. You must include appropriately signed 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 service

Please send this form and all additional documentation to

Fax: (803) 870-0139

Or mail to: JJ MAC - Palmetto GBA, LLC
Appeals - Part B
Mail Code: AG-655
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Columbia, SC 29202-3306