
Written Claim Review Request Form

The following “Request For Review of a Medicare Part B Claim” form simplifies and standardizes filing requirements for reviews. The review form allows the provider of services to clearly specify the reason(s) he or she disagrees with the original claim determination (section 5). The form also provides space for a comprehensive and detailed explanation of any additional information that should be considered when the claim is reviewed (section 7). Completion of these two sections is critical to the correct processing of your review request.

Using this review form will make handling requests for reviews easier and more efficient for providers’ offices. If all related information (dates of service, procedure codes, etc.) are filled in on the form as requested, copying and mailing of additional medical records could be significantly reduced (the current requirements for documentation for certain review types have not changed).

For your convenience a copy of the review form is provided on the following pages as well on our Florida Medicare provider website (www.floridamedicare.com). Follow the instructions on the reverse side of the form and submit your request to the address indicated in section 1.

Note: one form should be submitted per Medicare patient, per claim.

Request For Review of a Medicare Part B Claim

NOTICE - Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

Print legibly and complete all information. Only one form may be used per Medicare patient.

① **Carrier's Name and Address** Medicare B Review Department
P. O. Box 2360
Jacksonville, Florida 32231

② **Name of Patient**

③ **Medicare Health Insurance Claim Number**
(9 digits followed by an alpha/numeric suffix)

④ **I do not agree with the determination you made on ICN**

(1 form per patient)

⑤ **The reason(s) I disagree with the determination is/are :** (Please check those that apply)

Service/Claim underpaid/reduced

Service/Claim overpaid

Duplicate

Service(s) overutilized and/or not medically necessary

OTHER: (Please be specific) _____

⑥ **For services in question, please provide :**

Date(s) of Service:

Quantity Billed:

Modifier:

Procedure Code:

Date(s) of Service:	Quantity Billed:	Modifier:	Procedure Code:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

⑦ **Additional information to consider including specific diagnosis, illness and/or condition:**

⑧ **Attachments to consider:** (Please check all that apply)

Medical Records

Copy of Claim

Ambulance Run Sheet

Certificate of Medical Necessity

Office Records/Progress Notes

OTHER: (Please be specific) _____

⑨ **Signature of Claimant or Representative:**

Telephone Number:

(Print) _____

(Written) _____

**If you are providing a cover letter or attachments for multiple review cases;
you must have a separate copy for each review form submitted.**

PLEASE REFER TO THE BACK FOR AN EXPLANATION ON COMPLETING THIS FORM.

Rev. 8/4/98

Form #17503 798 SR

Instructions for Completing the *Request For Review Form*

Block ① - *Carrier's Name and Address*

All requests for review of Medicare Part 'B' Claims should be mailed to address indicated in this block.

Block ② - *Name of Patient*

Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

Block ③ - *Medicare Health Insurance Claim Number*

Enter the patient's Medicare Health Insurance Claim Number (HICN) as shown on the patient's Medicare card.

Block ④ - *I do not agree with the determination you made on ICN:*

Indicate the 13 digit Internal Control Number (ICN) assigned to the claim submitted for reimbursement. This number can be found on the Provider Claim Summary (PCS), Provider Remittance Notice (PRN) or Medicare Summary Notice (MSN).

Block ⑤ - *The reason(s) I disagree with the determination is/are:*

Check appropriate item(s) why you disagree with the decision made on the claim being submitted for review. If **OTHER** is checked, please provide specific information.

Block ⑥ - *For services in question, please provide:*

Please indicate on each line the date(s) of service and procedure code that you are requesting be reviewed. A consecutive date range may be used per line, however, it should be for only one procedure code.

➤➤ **Example of this would be:** 01/01/1998 - 01/12/1998 99232 ⚡⚡

Block ⑦ - *Additional information to consider including specific diagnosis, illness and/or condition:*

Provide any additional information that was not **originally** provided when the claim was submitted for processing.

Block ⑧ - *Attachments to consider:*

Check which attachments are being included with this form for consideration with the review of the claim being appealed.

Block ⑨ - *Signature of Claimant or Representative:*

Signature of claimant or his representative and telephone number.

Reminder

If you are providing a cover letter or attachments for multiple review cases; you must have a separate copy for each review form submitted.