

[INDIANA MEDICARE PART B REQUEST FOR REDETERMINATION/HEARING]

To request a Part B Redetermination, mail to:

Medicare Part B Redeterminations
P.O. Box 50410
Indianapolis, Indiana 46250-0410

To request a Part B Hearing, mail to:

Medicare Part B Hearings
P.O. Box 50462
Indianapolis, Indiana 46205-0462

Provider Name: _____ Provider Number: _____

Provider Address: _____

Name of Person Requesting the Redetermination: _____

Provider Telephone Number: _____ (_____) - _____ - _____ (Ext.) _____

Has this claim been reviewed by Appeals? ____ Yes ____ No
(If "Yes" check which type of Hearing requested below)

Type of Hearing: ____ In person ____ Telephone ____ On-the-record

Please check here if aggregating claims to meet \$100 controversy limit for a hearing

Beneficiary	Beneficiary #	Claim Control #	Service Date	Initial Determination Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Item(s) and Service(s) at issue in the appeal (Please be specific):

- ____ Request Made Within 120 days of claim determination. Redetermination letter attached. (If not, please attach letter stating why request is late.)
- ____ MSN attached
- ____ Claim Attached

Other documentation attached (i.e., operative report, path report, office notes, modifiers, etc.) Please specify below:

Signature: _____ Date: _____