



REDETERMINATION: 1ST LEVEL APPEAL

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 Region in which the services were provided:	
Provider Address	Requester Address				Patient Name	
					Medicare Beneficiary Identi	fier (MBI/HIC)
Provider Telephone & Extension	Requester Telephone & Extension					
() - x National Provider Identifier (NPI)	()	-	x	Claim Number (DCN)	
					Claim Date(s) of Service	
Provider Number (PTAN)					From	То -
Provider Tax Identification Number (TIN)						
REASON FOR APPEAL						
SUBMITTER INFORMATION						
Name (Please Print)	Signature				Date	

Please attach and include:

- 1. Please complete this form in its entirety.
- 2. Please complete only one form per beneficiary
- 3. 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:

Fax:(803) 870-0138

or mail to:

JJ MAC - Palmetto GBA, LLC
Appeals - Part A
Mail Code: AG-630
P.O. Box 100305
Columbia, SC 29202-3305

AP-JJ-A-1000