Medicare Part B Claim Inquiry or Review Request Form

This form may be used for one or multiple claims with the same issue. If your request involves multiple claims, you may attach a copy of your Standard Paper Remittance (SPR) to this form. Highlight the services you want reviewed.

Your request along with supporting documentation (medical notes, operative reports, test results, etc.) should be mailed to:

Medicare – GHI
P.O. Box 2870
New York, NY 10116-2870
Attn: Review Department

Date of Request: ___________________

Type of Request - Please check one.

___ **Review**: Complete Sections I, II, and IV. Failure to entirely complete all sections will result in your request being returned.

___ **Inquiry**: Complete Sections I, III, and IV.

Section I – Claim Information

Provider #:	**Beneficiary Health Insurance Claim Number (HIC):**
Provider Name:	**Beneficiary Name:**
Provider Address:	**Beneficiary Address:**
Claim Control Number (CCN):	**Procedure Code(s):**
Date(s) of Service:	**Billed Amount:**

Section II – Request for Review

I do not agree with the determination made on the claim(s) as described on the Standard Paper Remittance dated:____________

Reason for Review: ____

____

If the claim in question require any changes, please attach a corrected claim form. The beneficiary signature must be on the claim. Signature on file is acceptable.

If your request has exceeded the time limit for appeal, please include the reason for late filing with your request. You may attach additional sheets if necessary.

Reason for late filing: ____

____

Section III - Inquiry

Reason for Inquiry: ____

____

Section IV – Requestor Information

Requestor's Name and Title:	**Telephone Number:**
Requestor's Signature:	**Date Signed:**