



**WPS MEDICARE PART B
INDIANA APPEAL FAX**

(Please indicate which type of request you are submitting.)

REDETERMINATION REQUEST

Appeal of Overpayment (please include overpayment letter)

REOPENING REQUEST

To: Medicare Appeals Department
Fax Number: 608-224-3504
of pages _____ (including cover sheet)

**ALL REQUESTED INFORMATION ON THIS FAX FORM MUST BE COMPLETED.
INCOMPLETE FORMS MAY BE RETURNED TO THE SENDER.**

Provider Information

Date _____
Contact Name _____
Contact Phone Number _____

Claim Information

Claim ICN* in question _____

***ONE REQUEST FORM IS REQUIRED FOR EACH ICN. THE ICN IS LOCATED ON YOUR
REMITTANCE NOTICE.**

IMPORTANT NOTE:

- THIS FAX FORM **ALONE** DOES NOT QUALIFY AS A VALID REDETERMINATION REQUEST OR REOPENING REQUEST.
- YOU **MUST** ATTACH A VALID REQUEST TO THIS FAX FORM.
- REDETERMINATION AND REOPENING REQUEST FORMS ARE LOCATED ON THE WPS MEDICARE WEBSITE AT <http://www.wpsmedicare.com/j8macpartb/forms/appeals/>
- ALL REQUESTS WILL BE PROCESSED IN ACCORDANCE WITH INTERNET ONLY MANUAL (IOM) 100-04 CHAPTER 29 AND 34.

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL AND/OR PRIVILEGED. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY CALLING TOLL FREE 1-866-234-7331 AND CONFIRM DESTRUCTION OF THE INFORMATION. THANK YOU.