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.