



**WPS MEDICARE PART B
MISSOURI FAX**

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

☐ **REDETERMINATION REQUEST**

☐ **Appeal of Overpayment (please attach overpayment letter)**

☐ **REOPENING REQUEST**

To: Medicare Appeals Department

Fax Number: 608-223-7545

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/j5macpartb/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 AT 1 (866) 518-3285 AND CONFIRM DESTRUCTION OF THE INFORMATION. THANK YOU.