



**WPS MEDICARE PART B  
IOWA 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: 608-223-7541  
# 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 WEB SITE AT <http://www.wpsmedicare.com/j5macpartb/forms/>
- 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 1-866-503-3807 AND CONFIRM DESTRUCTION OF THE INFORMATION. THANK YOU.**

02/01/2012

<http://www.wpsmedicare.com/>

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\_\_\_\_\_, and we'll sign you up.