

Part B Overpayments Inquiry/Redetermination Request Form

This form is to be used by physicians/suppliers and facilities to submit general inquiries and redetermination requests to the Part B Debt Collection & Referral department.

Oklahoma Colorado New Mexico Texas/IHS Virginia

Physician/Supplier/Facility Name	National Provider Identifier (NPI) Number
Provider Transaction Access Number (PTAN)	Last Five Digits of the Tax Identification Number (TIN)
Address	Telephone Number
City, State and ZIP Code	Contact Person's Name
Patient's Name	Date of Service
Medicare Number	Date of Birth
Total Charges Submitted	CCN
Requestor's Name	Requestor's Signature
Reason for Inquiry	

Mail completed inquiry form to the following address:

TrailBlazer Health Enterprises, LLC
 Part B Debt Collection & Referral
 3101 S. Woodlawn
 Denison, TX 75020

TrailBlazerSM Web Site: <http://www.trailblazerhealth.com>
 Customer Service J4: (866) 280-6520
 Customer Service Virginia: (866) 717-0010

