



**Request to Open Rebuttal Period**

For instructions about completing and submitting this form, please refer to the next page

PROVIDER/SUPPLIER NAME: \_\_\_\_\_

NPI: \_\_\_\_\_

FEDERAL TAX-ID: \_\_\_\_\_

CLAIM#: \_\_\_\_\_

*If you do not wish to discuss a specific claim or claim numbers, please leave blank*

Type of Audit:  Automated - Date of RAC Demand Letter: \_\_\_\_\_

Complex – Date of RAC Review Results Letter: \_\_\_\_\_

Additional Documentation Attached:  Yes  No

I do not agree with the RAC’s decision for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Please submit additional page(s), if necessary*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Instructions**

You may submit this form and accompanying documentation by mail or fax.

If submitting by mail, please use a trackable method with delivery confirmation. Mail to:

Mississippi Division of Medicaid  
Office of Program Integrity  
Attn: Kameron M. Harris  
Walter Sillers Building, 550 High Street, Suite 1000  
Jackson, MS 39201

If submitting by fax, please use a fax cover form indicating the number of pages and fax to 601-576-4161. Please verify successful transmission by printing a confirmation/failure report.

For automated audits, please submit one form per Issue and attach a copy of the Demand Letter and a copy of the Overpayment Report page. If you are wishing to discuss specific claims, please circle those claims.

For complex audits, please submit one form for each decision and attach a copy of the RAC Review Results Letter for the case file in question.

If you have any questions, please call Customer Service at 1-800-880-5920 or submit an email to [MSRAC@medicaid.ms.gov](mailto:MSRAC@medicaid.ms.gov).



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