

Request to Appeal and ALJ ruling To the Medicare Appeals Council Step 33

It is possible to appeal an ALJ decision with the Medicare Appeals Council

This level of appeal is under a public forum, which means the final decision is published and can be used to set precedent for future cases.

If you choose to appeal to the Appeals Council, the ALJ Denial letter will provide details as to the process to submit the appeal.

To overturn an ALJ, you must provide evidence to clearly show that the ruling Judge made a mistake in applying the rule of law, simply disagreeing with the decision is not an acceptable reason to appeal.

Section	Instructions
1	Your company name here, you are the appellant
2	ALJ Appeal Number as listed on the ALJ ruling
3	Name of the Beneficiary
4	Health Insurance Claim Number (HICN)
5	Your company name here, you are the provider/supplier
6	List specific L-Codes or services being appealed
7	Check Part B
8	Check "NO" Include the specific dates of services
9	Check "NO"
10	Check appropriate box and input date. Include reasoning as to why the ALJ ruling was wrong, specifically what mistake was made or how ruling did not follow correct procedure.
11	Your signature and contact information, you are the appellant
12	Leave BLANK if you are representing yourself <ul style="list-style-type: none"> • <i>If you hired an attorney or a third party to represent you, provide the attorney contact information here.</i>

REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE (ALJ) MEDICARE DECISION / DISMISSAL

1. APPELLANT (the party requesting review) <div style="text-align: center;">Section 1</div>	2. ALJ APPEAL NUMBER (on the decision or dismissal) <div style="text-align: center;">Section 2</div>
3. BENEFICIARY* <div style="text-align: center;">Section 3</div>	4. HEALTH INSURANCE CLAIM NUMBER (HICN)* <div style="text-align: center;">Section 4</div>

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, and any other information to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER <div style="text-align: center;">Section 5</div>	6. SPECIFIC ITEM(S) OR SERVICE(S) <div style="text-align: center;">Section 6</div>
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7. Medicare claim type: Part A Part B Part C - Medicare Advantage
 Part D - Medicare Prescription Drug Plan Enrollment/enrollment for Part A or Part B

Section 7

8. Does this request involve authorization for an item or service that has not yet been furnished?
 Yes If Yes, skip to Block 9.
 No If No, Specific Dates of Service:

Section 8

9. If the request involves authorization for a prescription drug under Medicare Part D, would application of the standard appellate timeframe seriously jeopardize your life, health, or ability to regain maximum function (as documented by a physician) such that expedited review is appropriate? Yes No

Section 9

I request that the Medicare Appeals Council review the ALJ's decision or dismissal order [check one] dated _____. I disagree with the ALJ's action because (specify the parts of the ALJ's decision or dismissal you disagree with and why you think the ALJ was wrong):

Section 10

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ALJ DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

DATE APPELLANT'S SIGNATURE (the party requesting review) PRINT NAME ADDRESS CITY, STATE, ZIP CODE TELEPHONE NUMBER FAX NUMBER E-MAIL <div style="text-align: center;">Section 11</div>	DATE REPRESENTATIVE'S SIGNATURE (include signed appointment of representative if not already submitted.) PRINT NAME ADDRESS CITY, STATE, ZIP CODE TELEPHONE NUMBER FAX NUMBER E-MAIL <div style="text-align: center;">Section 12</div>
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(SEE FURTHER INSTRUCTIONS ON PAGE 2)

If you have additional evidence, submit it with this request for review. If you need more time, you must request an extension of time in writing now, explaining why you are unable to submit the evidence or legal argument now.

If you are a provider, supplier, or a beneficiary represented by a provider or supplier, and your case was reconsidered by a Qualified Independent Contractor (QIC), the Medicare Appeals Council will not consider new evidence related to issues the QIC has already considered unless you show that you have a good reason for submitting it for the first time to the Medicare Appeals Council.

IMPORTANT: Include the HICN and ALJ Appeal Number on any letter or other material you submit.

This request must be received within 60 calendar days after you receive the ALJ's decision or dismissal, unless we extend the time limit for good cause. We assume you received the decision or dismissal 5 calendar days after it was issued, unless you show you received it later. If this request will not be received within 65 calendar days from the date on the decision or dismissal order, please explain why on a separate sheet.

You must file your request for review in writing with the Medicare Appeals Council at:

Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6127
Cohen Building Room G-644
330 Independence Ave., S.W.
Washington, D.C. 20201

You may send the request for review by U.S. Mail, a common carrier such as FedEx, or by fax to (202) 565-0227. If you send a fax, please do not also mail a copy. ***You must send a copy of your appeal to the other parties and indicate that all parties, to include all beneficiaries, have been copied on the request for review. For claims involving multiple beneficiaries, you may submit a copy of the cover letters issued or a spreadsheet of the beneficiaries and addresses who received a copy of the request for review.***

If you have any questions about your request for review or wish to request expedited review of a claim involving authorization of your prescription drug under Medicare Part D, you may call the Medicare Appeals Council's staff in the Medicare Operations Division of the Departmental Appeals Board at (202) 565-0100. You may also visit our web site at www.hhs.gov/dab for additional information on how to file your request for review.

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, section 1155 of Title XI, and sections 1852(g)(5), 1869(b)(1), 1871, 1872, and 1876(c)(5)(B) of title XVIII, as appropriate). The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Department of Health and Human Services or the Social Security Administration to another person or governmental agency only with respect to programs under the Social Security Act and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services, the Social Security Administration, or other agencies.