# Medicare Reconsideration Form

This form is to file for a Redetermination to appeal a denial. (Step 25)

| Section | Instructions |
|---|---|
| 1 | Input the Beneficiary's full name |
| 2 | Input the Beneficiary's Medicare Number |
| 3 | Identify the specific codes that are being appealed (list the codes being denied) |
| 4 | Input the Date of Service |
| 5 | Date of the ReDetermination Notice from Medicare<br>Ensure to attach a copy of the ReDetermination with the form when submitting.<br>If it is being submitted more than 180 days after you received the ReDetermination notice, you must provide a detailed reason for the delay, note, I forgot or I was busy or I was on vacation is not an acceptable reason |
| 5a | Input the name of Medicare Contractor that determined the claim should be denied, note that this section is optional and the name is not required. |
| 5b | Check Yes or No, does this appeal involve an overpayment. This will be clearly identified on the Medicare ReDetermination notification |
| 6 | Provide a clear and concise statement as to why you do not agree with the ReDetermination decision<br>DO NOT write in "see attached" to refer to a letter or other documentation<br>Although you may wish to provide a letter with an extended explanation, it is imperative you summarize your appeal in one sentence in this section. |
| 7 | Only provide new information if it is relevant.<br>If the denial has remained unchanged, than your reason to appeal is also remained unchanged.<br>If you have new information that was not available for the ReDetermination appeal, provide either a list of reasons in this space or a list of enclosed documents that you are submitting to support the appeal. |
| 8 | Yes or No, you have additional evidence to submit.<br>This should only be marked "YES" in the event that you have NEW information that you did not submit with the ReDetermination appeal. |
| 9 | Check "Provider/Supplier" if the appeal is being submitted by the O&P Provider<br>Check "Representative" if an attorney or other third party is representing you for this case. |
| 10 | Input name, address, telephone number of the individual identified in section 9 |
| 11 | Signature of individual identified in section 9 |
| 12 | Date the form was signed. |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# MEDICARE RECONSIDERATION REQUEST FORM — 2ND LEVEL OF APPEAL

1. Beneficiary's name: _____ **Section 1**

2. Medicare number: _____ **Section 2**

3. Item or service you wish to appeal: _____ **Section 3**

4. Date the service or item was received: _____ **Section 4**

5. Date of the redetermination notice (please include a copy of the notice with this request):
*(If you received your redetermination notice more than 180 days ago, include your reason for the late filing.)*

_____ **Section 5**

_____

_____

5a. Name of the Medicare contractor that made the redetermination (not required if copy of notice attached): **Section 5a**

5b. Does this appeal involve an overpayment? ☐ Yes ☐ No **Section 5b**
*(for providers and suppliers only)*

6. I do not agree with the redetermination decision on my claim because:

_____ **Section 6**

_____

7. Additional information Medicare should consider:

_____ **Section 7**

_____

8. ☐ I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration. **Section 8**

☐ I do not have evidence to submit.

9. Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative **Section 9**

10. Name, address, and telephone number of person appealing: _____ **Section 10**

11. Signature of person appealing: _____ **Section 11**

12. Date signed: _____ **Section 12**

**PRIVACY ACT STATEMENT.** The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the 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 appeal. Information you furnish on this form may be disclosed by the Centers for Medicare and Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 71 Fed. Reg. 54489 (2006) or at http://www.cms.gov/PrivacyActSystemofRecords/downloads/0566.pdf