

Medicare Redetermination Form

This form is to file for a Redetermination to appeal a denial. (Step 19 or 21)

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 Initial Determination Notice from Medicare Ensure to attach a copy of the Notification with the form when submitting.
5a	Input the name of Medicare Contractor that determined the claim should be denied, note, 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 Initial Determination form
6	Provide a clear and concise statement as to why you do not agree with the determination decision DO NOT write in "see attached" to refer to a letter or other documentation, 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	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. Typically this will always be marked "Yes" as any letter, documents or information necessary to support this case is considered new evidence.
9	Check "Provider/Supplier" if the appeal is being submitted by the O&P Provider 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.

MEDICARE REDETERMINATION REQUEST FORM — 1ST 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 initial determination notice (please include a copy of the notice with this request):
(If you received your initial determination notice more than 120 days ago, include your reason for the late filing.)

Section 5

5a. Name of the Medicare contractor that made the determination (not required): _____

Section 5a

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

Section 5b

6. I do not agree with the determination 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 redetermination.
 I do not have evidence to submit.

Section 8

9. Person appealing: Beneficiary Provider 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 1809 (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>