Request for Medicare Hearing by an Administrative Law Judge
Step 29

Section	Instructions
1	Check Part B ✓ *Part A is hospital services and thus would never apply to any services provided by an O&P Provider.*
2	Check the "YES" box. ✓ *You only need to send one copy to the office of Medicare Hearings and Appeals Field office.* ✓ *You as the provider are the appellant so we already have a copy* ✓ *No other party is involved; this is between you the provider and Medicare.*
3	Your Company Name ✓ *You as the supplier are the appellant, you are appealing the denial*
4	Beneficiary Name & Contact Info ✓ *The beneficiary assigned benefits to you as the supplier* ✓ *Although the Beneficiary is not involved with the appeal, this information is necessary to confirm the case being appealed.*
5	Leave Blank ✓ *You supplier are the appellant, as per the instructions, leave this space blank*
6	Supplier Contact Info ✓ *Submit contact information for the supplier that provided the services.*
7	Medicare Claim Info ✓ *Copy this information directly from the denial letter* ✓ *Ensure dates of service are accurate*
8	List the Medicare Contractor that made the Reconsideration determination
9	List the Dates of Service for the Claim being appealed.
10	Reason for Appeal ✓ *Provide a one sentence clear explanation of why the denial is not justified.* ✓ *Ensure the appeal is directly related to the specific reason for denial.* ✓ *Example, if denial is related to the policy, the appeal must directly refer to the policy language* ✓ *If the denial is related to medical necessity, the appeal must directly refer to the fact that we meet policy standards for medical necessity.*
11	Check box; "I **wish** to have a hearing"
12	Check appropriate box ✓ *If you check the top box that you have additional information, you **MUST** include a good cause statement to explain why the evidence is being submitted for the first time at the ALJ level.* ✓ *Be advised, it must be a good reason, if all the evidence and documentation has not already been submitted before now without good reason, there is a high likelihood the request for ALJ will be denied.*
13	Leave Blank if you are representing yourself as the appellant If you have an have an attorney or third party representing your case ✓ *Check YES if you will accompany the representative (attorney) for the ALJ* ✓ *Check NO if you will NOT accompany the representative (attorney) for the ALJ*
14	**YOUR** signature and your Clinic Contact info ✓ *You are the appellant* ✓ *You are signing on behalf of your company*
15	Leave BLANK if you are representing yourself ✓ *If you hire an attorney or a third party to represent you, provide the attorney contact information here.*
16	Check Appropriate Box ✓ Yes or No, are multiple claims involved. ✓ Yes or No, are multiple beneficiaries involved. ✓ NO, beneficiary did not assign appeal rights because beneficiary is not the appellant. You are the appellant, the third box is always NO
17	Leave Blank ✓ *You are the appellant and are not representing the beneficiary; the beneficiary has no standing in this case.*
18	Leave BLANK if you are representing yourself ✓ *If you hire an attorney or a third party to represent you, have the representative sign*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

❑ Part A
❑ Part B

Effective July 1, 2005. For use by party to a reconsideration determination issued by a Qualified Independent Contractor (QIC)
(Amount in controversy must be $100 or more.)

Section 1

Send copies of this completed form to:
Original *— Office of Medicare Hearings and Appeals Field Office specified in the QIC Reconsideration Notice*
Copy *— Appellant* ***Copy*** *— All other parties*

Failure to send a copy of this completed request to the other parties to the appeal will delay the start date of your appeal.
Did you send all required copies? ❑ Yes ❑ No

Section 2

Appellant *(The party appealing the reconsideration determination)*

Section 3

Beneficiary *(Leave blank if same as the appellant.)*
Address
City State Zip Code
Area Code/Telephone Number E-mail Address
Health Insurance (Medicare) Claim Number

Section 4

Provider or Supplier *(Leave blank if same as the appellant.)*

Section 5

Address
City State Zip Code
Area Code/Telephone Number E-mail Address

Section 6

Document control number assigned by the QIC

Section 7

QIC that made the reconsideration determination

Section 8

Dates of Service From To

Section 9

I DISAGREE WITH THE DETERMINATION MADE ON MY APPEAL BECAUSE:

Section 10

You have a right to be represented at the hearing. If you are not represented but would like to be, your Office of Medicare Hearings and Appeals Field Office will give you a list of legal referral and service organizations. *(If you are represented and have not already done so, complete form CMS-1696.)*

Check **Only One** Statement:
❑ I **wish** to have a hearing.
❑ I **do not wish** to have a hearing and I request that a decision be made on the basis of the evidence in my case. *(See 42 CFR 405.1123, "Waiver of Right to an ALJ Hearing.")*

Section 11

Check **Only One** Statement:
❑ I **have** additional evidence to submit.
❑ I **have no** additional evidence to submit.

If you have additional evidence to submit, you must attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it. If you are a provider, supplier, or beneficiary represented by a provider or supplier, the evidence must be accompanied by a good cause statement explaining why the evidence is being submitted for the first time at the ALJ level.

Section 12

The appellant should complete No. 1 and the representative, if any, should complete No. 2. If a representative is not present to sign, print his or her name in No. 2. Where applicable, check to indicate if you will accompany the representative at the hearing. ❑ Yes ❑ No

Section 13

1. (Appellant's Signature) Date
Address
City State Zip Code
Area Code/Telephone Number E-mail Address

Section 14

2. (Representative's Signature/Name) Date
Address
❑ Attorney
❑ Non-Attorney
City State Zip Code
Area Code/Telephone Number E-mail Address

Section 15

Answer the following questions that apply:
A) Does request involve multiple claims? (If yes, a list of all the claims must be attached.) ❑ Yes ❑ No
B) Does request involve multiple beneficiaries? (If yes, a list of all the beneficiaries, their HICNs and the dates of service.) ❑ Yes ❑ No
C) Did the beneficiary assign his or her appeal rights to you as the provider/supplier? ❑ Yes ❑ No
(If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment.)

Section 16

Must be completed by the provider/supplier if representing the beneficiary:

I waive my rights to charge and collect a fee for representing _____ before the Office of Medicare Hearings and Appeals.
(Beneficiary name)

Section 17

Signature of provider/supplier representing beneficiary Date

ATTACH A COPY OF THE RECONSIDERATION DETERMINATION (IF AVAILABLE) TO THIS COPY.

Must be completed by the provider/supplier if representing the beneficiary, they furnished the item(s) or services(s) at issue, and the appeal involves a question of liability under section 1879(a)(2) of the Social Security Act:

I waive my right to collect payment from the beneficiary for the furnished items or services at issue involving 1879(a)(2) of the Social Security Act.

Section 16

Signature of provider/supplier representing beneficiary	Date

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS

Is this request filed timely? ❑ Yes ❑ No

If no, attach appellant's explanation for delay. If there is no explanation, send a Notice of Late Filing of Request for ALJ Hearing to the appellant and representative, if applicable, to request such an explanation.

Request received on	Field Office	Employee
Assigned on	Assigned by	Assigned to

Special response case? ❑ Yes ❑ No

If yes, explain why and state the targeted adjudication deadline.

Interpreter/translator needed (including sign language) ❑ Yes ❑ No

If yes, type needed:

If appellant not represented, has a list of legal referral and service organizations been provided. ❑ Yes ❑ No

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). 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 Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.