

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11 & 12, but to help us serve you better, please include a copy of the redetermination notice with your reconsideration request.

1. Name of Beneficiary: _____
- 2a. Medicare Number: _____
- 2b. Claim Number (ICN/DCN, if available): _____
3. Provider Name: _____
4. Person Appealing: Beneficiary Provider of Service Representative
5. Address of Person Appealing: _____
6. Item or service you wish to appeal: _____
7. Date of Service: From ___/___/___ To ___/___/___
8. Does this appeal involve an overpayment? Yes No
9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary). _____
10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:
 Medical Records Office Records/Progress Notes
 Copy of the Claim Treatment Plan Certificate of Medical Necessity
11. Printed Name of Person Appealing: _____
12. Signature of Person Appealing: _____ Date: ___/___/___

Contractor Number: 52280