maximus

Completing a Reconsideration Request

Tips for completing a reconsideration request:

Complete the form from the perspective of the person or entity sending the appeal request. "Person appealing" means you, the requester. Some forms say "Appellant," but this means the same thing. If you represent the provider or supplier as a separate entity (such as a billing agency), mark Representative.



You should include with your request some proof of representation. This may include:

- Power of attorney (for beneficiaries)
- Appointment of Representative (AOR) form
- Proof of billing agency representation We have a simple form we can offer for this use.

If relying on proof of representation in the PECOS tool, be sure the PECOS information is up to date! We see many cases where PECOS has old information.

Complete the "Name, address, and telephone number of person appealing" section with the exact information where you would like all correspondence to be directed.

	MEDICARE RECONSIDERATION REQUEST FORM — 2 ND LEVEL OF APPEAL
1.	Beneficiary's name:
2.	Medicare number:
3.	Item or service you wish to appeal:
4.	Date the service or item was received:
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.)
	5a. Name of the Medicare contractor that made the redetermination (not required if copy of notice attached)
	Sb. Does this appeal involve an overpayment? Yes No (for providers and suppliers only)
6.	I do not agree with the redetermination decision on my claim because:
7.	Additional information Medicare should consider:
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. I do not have evidence to submit.
9.	Person appealing: Beneficiary Provider/Supplier Representative
0.	Name, address, and telephone number of person appealing:
	Signature of person appealing:
	Date signed:
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For example: Billing Agency, c/o Provider/Supplier, 123 Main Street, Anytown, AA 12345

Don't forget:

- Include your company name (if not a beneficiary appeal).
- Include a suite/unit or reference a department if mail should be directed internally.
- Use "care of" or "on behalf of" the provider or supplier if you would like to keep such correspondence together.

Also, include the name of the provider or supplier somewhere in the appeal request. This will eliminate confusion between the actual supplier and the person or entity sending the appeal request.

Note: Some versions of this form have a line for the provider/supplier.

Questions?

Part A: 585-348-3020 PartAInfo@maximus.com

DME: 585-348-3200 DMEInfo@maximus.com

Download the reconsideration request form at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf

Remember!

- 1. Name of the Medicare beneficiary
- 2. Beneficiary's Medicare number
- 3. Item(s) appealed and dates of service
- 4. Name and signature of the person appealing
- 5. Name of the MAC that made the redetermination