MEDICARE REDETERMINATION REQUEST FORM — 1st LEVEL OF APPEAL

Beneficiary's name *(First, Middle, Last)*

Medicare number	Item or service you wish to appeal
Date the service or item was received *(mm/dd/yyyy)*	Date of the initial determination notice *(mm/dd/yyyy) (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:

Name of the Medicare contractor that made the determination *(not required)*	Does this appeal involve an overpayment? *(for providers and suppliers only)* ☐ Yes ☐ No

I do not agree with the determination decision on my claim because:

Additional information Medicare should consider:

☐ 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.

Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative	Email of person appealing (*optional)*

Name of person appealing *(First, Middle, Last)*

Street address of person appealing

City	State	Zip code

Telephone number of person appealing (*include area code)*	Date of appeal *(mm/dd/yyyy) (optional)*

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 & 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 83 Fed. Reg. 6591 (2/14/2018) or at **https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html**