Medicare Part B Reconsideration 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 the person appealing:	
5a. Telephone number of the person appealing:	
5b. Email of the person appealing:	
6. Item or service you wish to appeal:	
7. Date of service:	to
8. Does this appeal involve an overpayment?	☐ Yes ☐ No Please include a copy of the demand letter (if applicable) with your request.
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 Note ☐ Copy of Claim ☐ Treatment Plan ☐ Certificate of Medical
11. Printed name of person appealing:	
12. Signature of person appealing:	
Date:	

Contractor Name:	CGS Administrators, LLC
Contractor Number:	
Redetermination Number:	

Attn: C2C Innovative Solutions, Inc.
QIC Part B North
PO Box 45208
Jacksonville, FL 32232-5208

Originated December 8, 2016 | Revised March 2, 2017

CGS® CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES