RECONSIDERATION REQUEST FORM

Redetermination Number:

Contractor #: 18003, CGS, DME MAC - C

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 request.

Maximus Federal Services, Inc.,
Medicare DME
3750 Monroe Avenue, Suite 777
Pittsford, NY 14534-1302

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:

5a. Telephone Number of the Person Appealing:

5b. E-mail Address of the 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
   * 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 Notes ☐ Copy of the Claim ☐ Treatment Plan
    ☐ Certificate of Medical Necessity

11. Name of Person Appealing:

12. Date:

Contractor Number:

(Contractor number is optional for contractors withonly one location for QICs to request case files)

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