APPEAL INFORMATION COVER SHEET

Please include this completed form with your appeal.

Improperly submitted requests may be dismissed.

Provider/Supplier Name:

Provider/Supplier Address:

National Provider Identifier (NPI): **PTAN:**

Provider/Supplier Email Address:

Provider/Supplier Fax Number:

Medicare Administrative Contractor: CGS Administrators, LLC

This appeal submission is based on a(n): ☐ Denial ☐ Revocation ☐ Effective Date

Choose ALL that Apply

Are you submitting a Corrective Action Plan (CAP), Reconsideration Request, or both?

I am submitting a:	When submitting a CAP, it must:
☐ **Corrective Action Plan (CAP) –** *The CAP is an opportunity for the provider/supplier to correct the deficiencies (if possible) that resulted in the denial or revocation.* ***A CAP may only be submitted for denials under 42 C.F.R. § 424.530(a)(1) or revocations under 42 C.F.R. § 424.535(a)(1).***	1. Contain verifiable evidence that the provider/supplier is in compliance with Medicare requirements; 2. Be submitted within 35 days from the date of the denial or revocation notice; 3. Be submitted in the form of a letter that is properly signed and dated. A decision will be issued within 60 days of receipt of the CAP.

The time to submit a reconsideration request runs concurrently with the time to submit a CAP. For example, if a CAP is submitted 20 days after the initial determination, there are 45 days remaining to submit a reconsideration request. These 45 days continue to elapse while the CAP is under consideration. *Please note that failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.*

I am submitting a:	When submitting a reconsideration request, it must:
☐ **Reconsideration Request –** *A reconsideration request is an opportunity for a provider/supplier to furnish evidence that demonstrates that there was an error made at the time of the initial determination affecting participation in the Medicare Program.*	1. State the issues, or the findings of fact with which you disagree, and the reasons for disagreement. 2. Be submitted within 65 days from the date of the initial determination; 3. Be submitted in the form of a letter that is properly signed and dated. A decision will be issued within 90 days of receipt of the reconsideration request.

Your appeal submission must be PROPERLY SIGNED by the individual practitioner, an authorized or delegated official, or a legal representative.

- If the legal representative is an attorney, the appeal must also contain a statement that the attorney has the authority to act on behalf of the provider/supplier.
- If the legal representative is not an attorney, the appeal must contain written notice of the appointment of the non-attorney as legal representative signed by the individual practitioner or an authorized/delegated official.

You may submit your appeal by mail or email. Please send this completed form, the CAP and/or reconsideration request letter (signed and dated by the valid submitter), a copy of the initial determination letter, and all supporting documentation applicable to the appeal to the following address:

Part A

Mail: Centers for Medicare & Medicaid Services
Center for Program Integrity
Provider Enrollment & Oversight Group
ATTN: Division of Provider Enrollment Appeals
7500 Security Blvd.
Mailstop: AR-19-51
Baltimore, MD 21244-1850

OR

E-mail: ProviderEnrollmentAppeals@cms.hhs.gov

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES