

REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

Effective July 1, 2005. For use by party to a reconsideration determination issued by a Qualified Independent Contractor (QIC)
(Amount in controversy must meet threshold. See <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html>)

Part A
 Part B

Send copies of this completed form to:

ORIGINAL:
Office of Medicare Hearings and Appeals Field Office specified in the QIC Reconsideration Notice Copy

COPY: Appellant
COPY: All other parties

Failure to send a copy of this completed request to the other parties to the appeal will delay the start date of your appeal.

Did you send all required copies?
 Yes No

Appellant (The party appealing the reconsideration determination)

Beneficiary (Leave blank if same as the appellant)		Provider or Supplier (Leave blank if same as the appellant)	
Address		Address	
City, State, Zip Code		City, State, Zip Code	
Area Code / Phone Number	Email Address	Area Code / Phone Number	Email Address
Health Insurance (Medicare) Claim Number		Document control number assigned by the QIC	
QIC that made the reconsideration determination		Dates of Service FROM _____ TO _____	

I disagree with the determination made on my appeal because:

You have a right to be represented at the hearing. If you are not represented but would like to be, your Office of Medicare Hearings and Appeals Field Office will give you a list of legal referral and service organizations. (If you are represented and have not already done so, complete form CMS-1696.)

Check only one statement:

I wish to have a hearing

I do not wish to have a hearing and I request that a decision be made on the basis of the evidence in my case. (Complete form HHS-723, "Waiver of Right to an ALJ Hearing.")

Check only one statement:

I have additional evidence to submit

I have no additional evidence to submit

If you have additional evidence to submit, please attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it. If you are a provider, supplier, or beneficiary represented by a provider or supplier, the evidence must be accompanied by a good cause statement explaining why the evidence is being submitted for the first time at the ALJ level.

The appellant should complete No. 1 and the representative, if any, should complete No. 2. If a representative is not present to sign, **Yes** print his or her name in No. 2. Where applicable, check to indicate if appellant will accompany the representative at the hearing. **No**

1. Appellant's Signature	Date	2. Representative's Signature/Name	Date
Address		Address	<input type="checkbox"/> Attorney <input type="checkbox"/> Non-Attorney
City, State, Zip Code		City, State, Zip Code	
Area Code/Telephone Number	Email Address	Area Code/Telephone Number	Email Address

Answer the following questions that apply:

- A) Does request involve multiple claims? (If yes, a list of all the claims must be attached.) **Yes** **No**
- B) Does request involve multiple beneficiaries? (If yes, list beneficiaries, their HICNs and the dates of service.) **Yes** **No**
- C) Did the beneficiary assign his or her appeal rights to you as the provider/supplier? **Yes** **No**
- If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment.

Must be completed by the provider/supplier if representing the beneficiary:

I waive my rights to charge and collect a fee for representing _____ before the Office of Medicare Hearings and Appeals.
(Beneficiary Name)

Signature of provider/supplier representing beneficiary:	Date:
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Must be completed by the provider/supplier if representing the beneficiary, they furnished the item(s) or service(s) at issue, and the appeal involves a question of liability under section 1879(a)(2) of the Social Security Act:

I waive my right to collect payment from the beneficiary for the furnished items or services at issue involving 1879(a)(2) of the Social Security Act.

Signature of provider/supplier representing beneficiary:

Date:

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS

Is this request filed timely?

Yes No

If no, attach appellant's explanation for delay. If there is no explanation, send a Notice of Late Filing of Request for ALJ Hearing to the appellant and representative, if applicable, to request such an explanation.

Request received on:

Field Office:

Employee:

Assigned on:

Assigned by:

Assigned to:

Special Response Case? Yes No

If yes, explain why and state the targeted adjudication deadline.

Interpreter/translator/alternate format of communication needed (including sign language) Yes No

If yes, type needed:

If appellant not represented, has a list of legal referral and service organizations been provided? Yes No

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). 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 Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.