

WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Form revised 10/1/2019

Reconsideration Request 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, and 11 but to help us serve you better; please include a copy of the redetermination notice with your request.

Submit requests to: C2C Innovative Solutions Inc.

QIC Part B South P.O. Box 45300

Jacksonville, FL 32232-5300

| 1. Name of Beneficiary: | | | | |
|---|--------------------|---------------------|----------------|--|
| 2a. Medicare ID: | | | | |
| 2b. Claim Number (ICN/DCN if available): | | | | |
| 3. Provider Name: | | | | |
| 4. Person Appealing: | Beneficiary | Provider of Service | Representative | |
| 5. Address of the Person Appealing: | Address | | | |
| | City | State | ZIP Code | |
| 5a. Telephone Number of the Person Appeali | ng: | | | |
| 5b. Email Address of the Person Appealing:_ | | | | |
| 6. Item or service you wish to appeal: | | | | |
| 7. Date of the service: | From | To | | |
| 8. Does this appeal involve an overpayment? | Yes No | | | |
| Please include a copy of the demand letter | with your request. | | | |



| 9. Why do | o you disagree? Or what a | re your reasons for appeal | ? (255 charac | ter limit; attach additional pages if necessary.) |
|------------|----------------------------|-------------------------------|-----------------|---|
| 10. You n | nay also include any suppo | orting materials to assist yo | our appeal. Ex | amples of supporting materials include: |
| | Medical Records | Office Records/Progress | s Notes | Copy of the Claim |
| | Treatment Plan | Certification of Medical N | lecessity | |
| 11. Printe | ed Name of Person Appeal | ling: | | |
| | | | | |
| | | | | |
| Contracto | r Number | | Redetermination | n Number |



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