CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 151	Date: JULY 14, 2006
	Change Request 4354

SUBJECT: Provider Enrollment Appeals Process

I. SUMMARY OF CHANGES: The appeals process has been revised for providers and suppliers that wish to appeal a decision to deny or revoke enrollment in the Medicare program. Providers and suppliers will be given the right to a hearing by the administrative law judge within the Department of Health and Human Services.

NEW / REVISED MATERIAL
EFFECTIVE DATE: August 14, 2006
IMPLEMENTATION DATE: August 14, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/Table of Contents
R	10/19/Administrative Appeals
N	10/19.1/Model Letter Formation

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instructions

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 151	Date: July 14, 2006	Change Request 4354

SUBJECT: Provider Enrollment Appeals Process

I. GENERAL INFORMATION

A. Background: Section 936 of the Medicare Modernization Act (MMA) establishes an appeals process for providers and suppliers whose Medicare enrollment application has been denied or Medicare billing privileges revoked.

B. Policy: The Program Integrity Manual (PIM) Chapter 10, Section 19 has been revised to include the implementation of the new appeals provisions of Section 936 of the MMA. This appeals process will apply to all providers and suppliers, not just those defined in 42 Code of Federal Regulations (CFR) 498. A provider, supplier or Medicare contractor will be given the right to a hearing by the Administrative Law Judge (ALJ) within the Department of Health and Human Services (DHHS) after an adverse decision at the reconsideration level resulted in a denial or revocation of billing privileges. Further appeal rights will be determined by the outcome of the ALJ decision but could include a review of the ALJ's decision by the Departmental Appeals Board (DAB) and a Judicial review.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4354.1	Contractors shall use the appeals process described in the PIM, Chapter 10, Section 19 regardless of the provider or supplier type.	X	X	X	X					NSC
4354.2	If a Medicare contractor reviews an initial - application and finds that the provider/supplier does not meet one or more of the Federal or State requirements, the contractor shall deny the application or recommend a denial to the Regional Office (RO).	X	X	X	X					NSC
4354.3	If the Medicare contractor discovers that a provider/supplier no longer meets one of the	X	X	X	X					NSC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	requirements for a billing number the contractor shall revoke their billing privilege or recommend revocation to the RO.									
4354.4	The Medicare contractor or RO shall inform the provider or supplier, in a denial/revocation letter, their right to request a reconsideration by a contractor hearing officer or RO personnel.		X	X	X					RO, NSC
4354.5	The provider, supplier or Medicare contractor should appeal the reconsideration to the ALJ if they are not in agreement with the decision.	X	X	X	X					NSC
4354.6	The Medicare contractor shall notify and consult with their Division of Provider/Supplier Enrollment (DPSE) liaison prior to filing a request for an ALJ hearing.	X	X	X	X					NSC
4354.7	If the provider, supplier or Medicare contractor requests an ALJ hearing, an Office of General Counsel (OGC) attorney shall be assigned to the case.									DPSE
4354.8	The Medicare contractor shall provide any assistance or documentation required by the OGC attorney.	X	X	X	X					NSC
4354.9	Contractors shall, if asked by OGC or CMS, participate in pre-settlement calls, remand discussions, or any other matter relating to the case.	X	X	X	X					NSC
4354.10	Contractors who are not in agreement with the ALJ decision should request a further review by the DAB and if there are still unresolved issues a Judical review is available.	X	X	X	X					NSC

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: August 14, 2006 **Implementation Date:** August 14, 2006 **Pre-Implementation Contact(s):** Alisha Banks, 410-786-0671, alisha.banks@cms.hhs.gov **Post-Implementation Contact(s):** Alisha Banks, 410-786-0671, alisha.banks@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Program Integrity Manual
Chapter 10 - Healthcare Provider/Supplier Enrollment

Table of Contents
(Rev. 151, 07-14-06)

19 - Administrative Appeals

(Rev. 151, Issued: 07-14-06; Effective/Implementation Dates: 08-14-06)

A provider or supplier whose Medicare enrollment is denied or whose Medicare billing privilege is revoked can request an appeal of that initial determination. This appeal process applies to all provider and supplier types, not just those defined in 42 C.F.R. § 498, and ensures that all applicants receive a fair and full opportunity to be heard. With the implementation of the appeals provision of Section 936 of the Medicare Prescription Drug Modernization and Improvement Act ("MMA"), all providers and suppliers that wish to appeal will be given the opportunity to request an appeal of a contractor hearing decision to an Administrative Law Judge ("ALJ") of the Department of Health and Human Services ("DHHS"). Providers and suppliers then can seek review by the Departmental Appeals Board ("DAB") and then may request judicial review.

Denial of an Enrollment Application/Revocation of Medicare Billing Privileges

A. Carriers (including NSC)

If a Medicare contractor reviews an initial enrollment application for a provider or supplier and finds a basis for denying the application pursuant to 42 C.F.R. § 424.30, such as; the provider or supplier does not meet one or more of the Federal or State requirements, then the Medicare contractor will deny the application and send a denial letter explaining the reason for the denial to the provider or supplier. The letter will provide appeal rights and include the procedures for requesting Medicare contractor reconsideration. Contractor reconsiderations can be conducted by a Hearing Officer (HO) or senior staff having expertise in provider enrollment and independent from the initial decision to deny or revoke enrollment.

Similarly, when a Medicare contractor discovers that there is a basis for revoking a provider or supplier's billing number, such as; a provider or supplier that no longer meets one of the requirements for a billing number, then the provider or supplier's billing number is revoked. The contractor sends the provider or supplier a letter that explains the reason for revoking their billing number, the effective date of the revocation (30 days from the date the notice is mailed), appeal rights and procedures for requesting Medicare contractor reconsideration.

Request for Reconsideration (formerly Contractor Hearing)

A provider or supplier that wishes to request a reconsideration must file its request, in writing, with the Medicare contractor within 60 days and a DMEPOS supplier must file its request within 90 days after the postmark of the notice to be considered timely filed. The date the request is received by the contractor is treated as the date of filing. Failure to timely request a contractor hearing is deemed a waiver of all rights to further administrative review. The request must be signed by the physician, non-physician practitioner, or any responsible authorized official within the entity. For DMEPOS suppliers, the request must be signed by the authorized representative, owner or partner.

Upon receipt of the reconsideration, the Medicare contractor must send an acknowledgment letter to the provider or supplier to acknowledge receipt of their request. In its acknowledgment letter, the contractor shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90 days from the date of the request. The contractor shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1. The language therein may need to be modified, depending upon: (1) whether it is the contractor or hearing officer (HO) assigned to the case that is sending out the acknowledgment, and (2) any special circumstances involved in the case.

If a timely request for a reconsideration is made, a HO, not involved in the original determination to deny enrollment, must hold an on-the-record reconsideration and issue a determination within 90 days of receipt of the appeal request. The provider, supplier or the contractor may offer new evidence. The burden of persuasion are on the provider or supplier to show that its enrollment application was incorrectly disallowed or billing privileges revoked erroneously. The reconsideration is a thorough, independent review of the contractor's initial determination and the entire body of evidence, including any new information submitted.

If a request for reconsideration is filed late, the HO makes a finding of good cause before taking any other action on the appeal. These time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- *Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or*
- *Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.*

The HO issues a written decision as soon as practicable, but no later than 90 days from the date of the request and forwards the decision to the Medicare contractor and by certified mail to the provider, supplier or his authorized representative. The decision includes (i) information about the provider, supplier, or contractor's further right to appeal; (ii) the address to which the written appeal must be mailed; (iii) the date by which the appeal must be filed; and (iv) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.) A model decision letter can be found in §19.1.

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the Medicare contractor.

When the Medicare contractor receives a withdrawal request, it sends a letter to the provider or supplier acknowledging its receipt and advising that reconsideration action will be terminated.

Contractors shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested). Contractors are not required to submit this information to CMS but it must be provided upon request.

Request for Administrative Law Judge (ALJ) Hearing

If the provider, supplier or Medicare contractor is not in agreement with the reconsidered determination a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from receipt of the reconsideration decision. Prior to filing an appeal with the ALJ, the contractor should notify and consult with their DPSE contractor liaison. ALJ requests should be sent to:

Department of Health and Human Services
Departmental Appeals Board (DAB)
Civil Remedies Division, Mail Stop 6132
220 Independence Avenue, S.W.
Cohen Bldg, Room G-644
Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

Upon receipt of the request to file an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider or supplier, CMS, and the Medicare contractor, listing an assigned ALJ to the case and a scheduled prehearing conference. The DPSE will notify the Office of General Counsel (OGC) regarding the filings and request an attorney participate on the case. The assigned attorney will also serve as the DAB point of contact. Neither CMS nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing conference to discuss any issues. The OGC counsel will represent CMS during the pre-hearing conference and any settlement proposals will be addressed with CMS. The Medicare contractors shall work with and provide the OGC attorney with all necessary documentation.

Failure to timely request an ALJ hearing is deemed a waiver of all rights to further administrative review. An HO's partial or complete reversal of a contractor's initial determination is not implemented pending the contractor's decision to appeal the reversal to the ALJ, unless the contractor, in its sole discretion, and without prejudice to its right to appeal, decides to implement the reversal pending an appeal. The contractor implements a reversal if it decides not to appeal a reversal to the ALJ, or the time to

appeal expires. A contractor may implement a HO's partial reversal even if the provider or supplier has appealed the partial reversal to the ALJ, or the time for the provider or supplier to file an appeal has not expired.

Request for Departmental Appeals Board (DAB) Hearing

If there are still outstanding issues once the ALJ rules on the case, any of the parties may request a DAB review. A provider, supplier or Medicare contractor that wishes to request a review by the DAB must file its request within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the Board considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. Additional information may be presented orally to the Board which will be prepared by transcript and made available to any party upon request.

Request for Judicial Review

Any provider, supplier, or Medicare contractor dissatisfied with a DAB decision has a right to seek judicial review by timely filing a civil action in a United States District Court. The time limit for filing is 60 days from receipt of the notice of the DAB's decision.

B. Fiscal Intermediary

If a Medicare contractor reviews an initial enrollment application for a provider or certified suppliers and finds that the application could be denied pursuant to 42 C.F.R § 424.530, such as; a facility's failure to meet one or more of the federal or state requirements, then the Medicare contractor sends a recommendation for denial to the CMS Regional Office (RO). If the RO finds that the contractor's recommendation is consistent with the applicable rules and regulations, a denial letter is sent to the provider or certified supplier explaining the reason for the denial. The letter will provide appeal rights and include the procedures for requesting RO reconsideration.

Similarly, when a Medicare contractor or the State Survey and Certification agency discover that a provider or certified supplier no longer meets one of the requirements for a billing number they contact the RO and recommend revocation of their billing privilege. If the RO finds that the contractor's recommendation is consistent with the applicable rules and regulations, a letter is sent to the provider or certified supplier explaining the reason for the revocation of billing privileges, the effective date of the

revocation (15 days from the date the notice is mailed), appeal rights and procedures for requesting a RO reconsideration.

Request for RO Reconsideration

A provider or certified supplier that wishes to request a reconsideration must file its request, in writing, with the RO within 60 days after the postmark of the notice to be considered timely filed. The date the request is received by the RO is treated as the date of filing. Failure to timely request a RO hearing is deemed a waiver of all rights to further administrative review. The request may be signed by the authorized official within the entity.

Upon receipt of the reconsideration, the RO must send an acknowledgment letter to the provider or certified supplier to acknowledge receipt of their request. In its acknowledgment letter, the RO shall advise the requesting party that the reconsideration will be conducted and a determination issued as soon as possible, but no later than 90 days from the date of the request. The RO shall include a copy of its acknowledgment letter in the reconsideration file. A model acknowledgment letter can be found in §19.1.

If a timely request for a reconsideration is made, a RO personnel, not involved in the original determination to deny enrollment, must hold an on-the-record reconsideration and issue a determination within 90 days of receipt of the appeal request. The provider, certified supplier or the contractor may offer new evidence. The burden of persuasion are on the provider or certified supplier to show that its enrollment application was incorrectly disallowed or billing privileges revoked erroneously. The reconsideration is a thorough, independent review of the contractor's initial determination and the entire body of evidence, including any new information submitted.

If a reconsideration request is filed late, the RO makes a finding of good cause before taking any other action on the appeal. These time limits may be extended if good cause for late filing is shown. Good cause may be found when the record clearly shows, or the party alleges and the record does not negate that the delay in filing was due to one of the following:

- *Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or*
- *Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.*

The RO issues a written decision as soon as practicable, but no later than 90 days from the date of the request and forwards the decision by certified mail to the Medicare contractor, the provider, certified supplier or his authorized representative. The decision includes (i) information about the provider, supplier, or contractor's further right to appeal; (ii) the address to which the written appeal must be mailed; (iii) the date by

which the appeal must be filed; and (iv) the information the appellant must include with their appeal (that is, their name, provider/supplier number (if applicable), their Internal Revenue Service TIN/EIN, and a copy of the reconsideration decision.) A model decision letter can be found in §19.1.

A request for reconsideration may be withdrawn at any time prior to the mailing of the reconsideration decision either by the party that filed the appeal request or their authorized representative. The request for withdrawal must be in writing, signed, and filed with the RO.

When the RO receives a withdrawal request, it sends a letter to the provider or certified supplier acknowledging its receipt and advising that reconsideration action will be terminated.

The RO shall maintain a report detailing the number of reconsideration requests they receive and their outcome (e.g., decision withheld, reversed, or further appeal requested). The RO are not required to submit this information to CMS but it must be provided upon request.

Request for ALJ Hearing

If the provider, certified supplier or Medicare contractor is not in agreement with the reconsidered determination a further appeal can be filed with an ALJ. The ALJ has delegated authority from the Secretary of the Department of Health and Human Services (DHHS) to exercise all duties, functions, and powers relating to holding hearings and rendering decisions. Such appeal must be filed, in writing, within 60 days from the receipt of the reconsideration decision. Prior to filing an appeal with the ALJ, the contractor should notify and consult with their DPSE contractor liaison. ALJ requests should be sent to:

Department of Health and Human Services
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220 Independence Avenue, S.W.
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Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

Upon receipt of the request to file an ALJ hearing, an ALJ at the Departmental Appeals Board (DAB) will issue a letter by certified mail to the provider or certified supplier, CMS, the RO and the Medicare contractor, listing an assigned ALJ to the case and a scheduled prehearing conference. The DPSE will notify the Office of General Counsel (OGC) regarding the filings and request an attorney participate on the case. The assigned attorney will also serve as the DAB point of contact. Neither CMS, the RO nor the Medicare contractor are required to participate in the pre-hearing conference but should coordinate among themselves and the OGC attorney prior to the pre-hearing

conference to discuss any issues. The OGC counsel will represent CMS during the pre-hearing conference and any settlement proposals will be addressed with CMS. The Medicare contractor shall work with and provide the OGC attorney with all necessary documentation.

Failure to timely request the ALJ hearing is deemed a waiver of all rights to further administrative review. An RO's partial or complete reversal of its decision to deny enrollment or revoke billing privileges is not implemented pending the contractor's decision to appeal the reversal to the ALJ, unless the contractor, in its sole discretion, and without prejudice to its right to appeal, decides to implement the reversal pending an appeal. The contractor implements a reversal if it decides not to appeal a reversal to the ALJ, or the time to appeal expires. A contractor may implement a RO's partial reversal even if the provider or certified supplier has appealed the partial reversal to the ALJ, or the time for the provider or certified supplier to file an appeal has not expired.

Request for DAB Hearing

If there are still outstanding issues once the ALJ rules on the case any of the parties may request Departmental Appeals Board review. A provider, certified supplier or Medicare contractor that wishes to request a review by the DAB must file its request within 60 days after the date of receipt of the ALJ's decision. Failure to timely request a review by the DAB is deemed a waiver of all rights to further administrative review.

The DAB will use the information in the case file established at the reconsideration level and any additional evidence introduced at the ALJ hearing. The DAB may admit additional evidence into the record if the Board considers it relevant and material to an issue before it. Before such evidence is admitted, notice is mailed to the parties stating that evidence will be received regarding specified issues. The parties are given a reasonable time to comment and to present other evidence pertinent to the specified issues. Additional information may be presented orally to the Board which will be prepared by transcript and made available to any party upon request.

Request for Judicial Review

Any provider or certified supplier dissatisfied with DAB review has a right to seek judicial review by timely filing a civil action in a United States District Court. The time limit for filing is 60 days from receipt of the notice of the DAB's decision.

19.1 – Model Letter Formation

(Rev. 151, Issued: 07-14-06; Effective/Implementation Dates: 08-14-06)

MODEL ACKNOWLEDGMENT LETTER FORMATION

CMS alpha representation
PART B CARRIER
Or
NATIONAL SUPPLIER CLEARINGHOUSE (NSC)
Or
CMS REGIONAL OFFICE
Appeals Phone Number

ACKNOWLEDGMENT OF REQUEST FOR RECONSIDERATION BY [A CONTRACTOR HEARING OFFICER or CMS REGIONAL OFFICE] [On a copy of the acknowledgement letter addressed to other parties, include a statement indicating that this is a copy of the acknowledgment of a request for a Reconsideration by a Contractor Hearing Officer or CMS Regional Office]

Date:

Appellant's Name

Appellant's Address

RE:

Application for (identify type of application submitted, supplier type, etc.)

Dear Name of Appellant:

Your request for a reconsideration was received on [date that reconsideration request was received in the corporate mailroom].

Use either of the following:

A Hearing Officer or CMS RO will be assigned to this case who will make a new and independent decision based on the evidence in the case file and on any additional

evidence that you would like to submit. A determination will be issued no later than 90 days from the date of your request.[OR]

I am the Hearing Officer assigned to this case, and I will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit. A determination will be issued no later than 90 days from the date of your request.

If you need more information or have any questions, feel free to contact (appropriate name) at (phone number).

Sincerely,

(Name of Individual)
(Title)
Cc:
Medicare Government Services
I Jones Street
(City), (State) (Zip)

A CMS CONTRACTED CARRIER

MODEL DECISION LETTER FORMATION

CMS alpha representation
PART B CARRIER
Or
NATIONAL SUPPLIER CLEARINGHOUSE (NSC)
Or
CMS REGIONAL OFFICE
Appeals Phone Number

*This is a **MEDICARE** [Hearing Officer or CMS Regional Office]*
RECONSIDERATION DECISION

Date:

Appellant's Name

Appellant's Address

RE: Application for Medicare Provider Enrollment for {Enter Provider's Name}
Reconsideration Case Number/Document Control Number:

This decision is [UNFAVORABLE/FULLY FAVORABLE]. Please see FURTHER APPEAL RIGHTS for your next level of appeal.

Dear Name of Appellant:

You asked that a reconsideration be conducted by [a contractor Hearing Officer (HO) or the CMS Regional Office] to re-evaluate the [Carrier's or Regional Office's] decision on (Name of Provider/Supplier) request to participate in the Medicare program. I am an authorized Hearing Officer for (Name of Contractor).

This letter contains my on-the-record decision, on your Medicare Provider/Supplier Enrollment Hearing.

[The language in the introductory paragraph may be modified and/or additional information inserted as you deem necessary.]

FACTS:

The HO or RO should include all the relevant factual data that was part of the file prior to the reconsideration.

ISSUE(S):

The issue(s) should be specific to the case rather than generic. The issue(s) statement should be stated as a question. For example, "Did the contractor properly deny the enrollment application in this case, based on the facts and applicable law?"

DECISION:

Insert a brief statement of the decision, for example "Based on the available evidence/information, I find that the Contractor or RO properly denied the enrollment application in this case." The decision statement should answer the question(s) asked under the ***ISSUE(S)*** *section, above.*

RATIONALE:

This is the most important element of the reconsideration. Explain the logic/reasons that led to your final determination. Explain what policy, regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it included an explanation of why the application was denied.

FURTHER APPEAL RIGHTS - ADMINISTRATIVE LAW JUDGE HEARING

If you are satisfied with this decision, you do not need to take further action.

If you are ***not*** *satisfied with this decision, you may file an appeal with an Administrative Law Judge (ALJ) for further administrative review. You must file your appeal within 60 days after the date of receipt of this decision by writing to the following address:*

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division, Mail Stop 6132
220 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
ATTN: CMS Enrollment Appeal

You must include the following information with your request for the ALJ hearing:

- *Your name (i.e., the name of the physician, non-physician practitioner, or entity)*
- *The Medicare billing identification number (if applicable)*
- *The IRS tax identification number (TIN) or employer identification number (EIN), and*
- *A copy of the Hearing Officer's or RO's decision*

Failure to timely request a final review by the ALJ is deemed a waiver of all rights to further administrative review.

Sincerely,

(Name of Individual)
(Title)
Cc:
Medicare Government Services
I Jones Street
(City), (State) (Zip)

A CMS CONTRACTED CARRIER