DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

Effective July 1, 2005. For use by party to a reconsideration/fair hearing determination issued by a Fiscal Intermediary (FI), Carrier, or Quality Improvement Organization (QIO)
(Amount in controversy must be $100 or more.)

❑ **Part A**
❑ **Part B**

Send copies of this completed form to:
Original *— The FI, Carrier, or QIO that issued the Reconsideration/Fair Hearing Notice*
Copy *— Appellant*

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/Telephone Number	E-mail Address		Area Code/Telephone Number	E-mail Address	
Health Insurance (Medicare) Claim Number			Document control number assigned by the FI, Carrier, or QIO		
FI, Carrier, or QIO that made the reconsideration/fair hearing 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:		Check **Only One** Statement:	
❑	I **wish** to have a hearing.	❑	I **have** additional evidence to submit.
❑	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.")*	❑	I **have no** additional evidence to submit.

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

1. (Appellant's Signature)			Date	**2.** (Representative's Signature/Name)			Date
Address				Address			❑ Attorney ❑ Non-Attorney
City	State	Zip Code		City	State	Zip Code	
Area Code/Telephone Number	E-mail Address			Area Code/Telephone Number	E-mail Address		

Answer the following questions that apply:

A) Does request involve multiple claims? ❑ Yes ❑ No
(If yes, a list of all the claims must be attached.)

B) Does request involve multiple beneficiaries? ❑ Yes ❑ No
(If yes, a list of beneficiaries, their HICNs and the dates of the applicable reconsideration determinations must be attached.)

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.)

D) If there was no assignment, are you a physician being held liable pursuant to 1842(l)(1)(A) of the Social Security Act? ❑ Yes ❑ No

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 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

Has a copy of this form been sent to all other parties? ❑ 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. The Social Security Number will be used to verify the identity of the individual appellant. 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.