DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) OR CMS CONTRACTOR PARTICIPATION AS A NON-PARTY OR AS A PARTY TO AN ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

(For use when the Qualified Independent Contractor (QIC) issues the reconsideration determination.)

Appellant

Beneficiary *(leave blank if same as appellant)*

Provider/Supplier *(leave blank if same as appellant)*

QIC that issued the reconsideration determination

Health Insurance Claim (HIC) Number	ALJ Appeal Number

1. This notice is in response to a request for participation from the Administrative Law Judge (ALJ) *(check one)*

☐ Yes ☐ No

2. The CMS or its contractor(s) intends to participate in the ALJ hearing held by the Office of Medicare Hearings and Appeals (OMHA) *(check one)*

☐ Yes ☐ No

If you answered "Yes" to Item 2, please complete the remainder of the form and mail a copy of this completed form to the ALJ assigned to the appeal, the Appellant, and all other parties identified in the Notice of Hearing. (If you do not have this information, please contact this office.) If you answered "No" to Item 2, you only need to complete Item 16 of the form and only need to mail it to the ALJ.

3. CMS or its contractor(s) intends to *(check one)*

☐ Participate in the hearing process as a non-party; or ☐ Participate in the hearing process as a party.

4a. Entity that intends to participate *(check one)*

☐ CMS ☐ CMS contractor

4b. If a CMS contractor intends to participate, please complete the following:

Contractor Name		Point of Contact (POC)	
Street	City	State	ZIP Code
POC Telephone Number ( )		POC Alternate Telephone Number ( )	
POC FAX Number ( )		POC E-Mail	

4c. If CMS intends to participate, please complete the following:

CMS Office Name		Point of Contact (POC)	
Street	City	State	ZIP Code
POC Telephone Number ( )		POC Alternate Telephone Number ( )	
POC FAX Number ( )		POC E-Mail	

5. Please complete the following information regarding the representative *(if you need additional room please attach a sheet of paper)*

Representative Name		Organization	
Street	City	State	ZIP Code
Telephone Number ( )		Alternate Telephone Number ( )	
FAX Number ( )		E-Mail	

IF YOU ARE PARTICIPATING AS A NON-PARTY, PLEASE ANSWER THE FOLLOWING QUESTIONS

6. Do you intend to submit position paper(s)? ☐ Yes ☐ No

7. Do you intend to provide written testimony? ☐ Yes ☐ No

8. Do you intend to provide clarification of points? ☐ Yes ☐ No

Please provide further explanation on the items CMS or its contractors intends to submit:

IF YOU ARE PARTICIPATING AS A PARTY, PLEASE ANSWER THE FOLLOWING QUESTIONS

9. Do you intend to submit position paper(s)? ☐ Yes ☐ No

10. Do you intend to provide written testimony? ☐ Yes ☐ No

11. Do you intend to provide clarification of points? ☐ Yes ☐ No

12. Do you intend to provide oral testimony? ☐ Yes ☐ No

13. Do you intend to call additional witnesses? ☐ Yes ☐ No

14. Do you intend to submit additional information? ☐ Yes ☐ No

15. Do you intend to request discovery of other parties to the hearing? ☐ Yes ☐ No

Please provide further explanation on the items CMS or its contractors intend to submit:

16. Representative or Point of Contact Name	Representative or Point of Contact Signature	Date

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(h)(I), 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.