## MEDICARE REDETERMINATION REQUEST FORM

1.	Beneficiary's Name:
	Medicare Number:
3.	Description of Item or Service in Question:
4.	Date the Service or Item was Received:
5.	I do not agree with the determination of my claim. MY REASONS ARE:
6.	Date of the initial determination notice
	(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)
7.	Additional Information Medicare Should Consider:
8.	Requester's Name:
9.	Requester's Relationship to the Beneficiary:
10.	Requester's Address:
11.	Requester's Telephone Number:
12.	Requester's Signature:
13.	Date Signed:
14.	<ul> <li>☐ I have evidence to submit. (Attach such evidence to this form.)</li> <li>☐ I do not have evidence to submit.</li> </ul>

**NOTICE:** Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.