



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

FILING OF NEW EVIDENCE

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

PARTY INFORMATION

| | | | |
|--|--|-------------------------------------|--|
| Party Name <i>(who is filing the evidence)</i> | | Street | |
| City | State | ZIP Code | |
| Telephone Number () | Alternate Telephone Number () | | |
| FAX Number () | E-Mail | | |
| Beneficiary Name <i>(Leave blank if same as party name)</i> | | Health Insurance Claim (HIC) Number | |
| Provider or Supplier <i>(Leave blank if same party name)</i> | | ALJ Appeal Number | |

INSTRUCTIONS ON FILING NEW EVIDENCE

Submitting Additional Evidence

The following requirements do **not** apply to unrepresented beneficiaries.

Any additional written evidence you want the ALJ to review must be submitted **within 10 calendar days** of receiving the Notice of Hearing from the Office of Medicare Hearings and Appeals (OMHA). If evidence is submitted later than 10 calendar days, the time between when the evidence was required to be submitted and when it was actually received will not be counted towards the time during which the ALJ must issue a decision.

Additional Requirements That Apply to Providers, Suppliers or Beneficiaries Represented by Providers or Suppliers

If you are a provider, supplier, or beneficiary represented by a provider/supplier, any written evidence you wish the ALJ to review that was not submitted prior to the QIC's reconsideration determination must be accompanied by a statement explaining why the evidence was not previously submitted. The ALJ has the discretion to accept or deny this evidence based upon a showing of good cause. (An example of good cause would be that the new evidence relates to an issue that was not previously decided at the QIC level.)

DESCRIPTION OF EVIDENCE

Please describe the new evidence you wish to submit. Include the title, relevance, and date of creation in your description. If you are required to do so, also include a good cause statement explaining why this evidence was not previously submitted. Please attach the evidence. If you need additional room, attach a separate sheet of paper.

| | |
|--|------|
| Party Signature <i>(Party submitting the new evidence (or party's representative))</i> | 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.