DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM

1. Beneficiary's Name: _____

2. 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 redetermination notice _____

(If you received your redetermination more than 180 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. ☐ I have evidence to submit. (Attach such evidence to this form.)
☐ I do not have evidence to submit.

15. Name of the Medicare Contractor that Made the Redetermination: _____

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