REQUEST FOR REVIEW OF ADMINISTRATIVE LAW JUDGE MEDICARE DECISION / ORDER

1. APPELLANT (the party requesting review)	2. DOCKET NUMBER (if any)*
3. BENEFICIARY*	4. HEALTH INSURANCE CLAIM NUMBER (HICN)*

*If the request involves multiple claims or multiple beneficiaries, attach a list of beneficiaries, HICNs, docket numbers, or other information as needed to identify all claims being appealed.

5. PROVIDER, PRACTITIONER, OR SUPPLIER	6. DATE(S) OF SERVICE (for pre-service claims, leave blank and fill out Block 7)

7. Does this request for review involve authorization for an item or service that has not yet been furnished? ☐ Yes ☐ No
If Yes, please describe the item or service:

8. MEDICARE CONTRACTOR (Carrier, Fiscal Intermediary, HMO, or other Medicare + Choice organization)

9. I request that the Medicare Appeals Council review the Administrative Law Judge's ☐ decision or ☐ dismissal order [check one] dated_____ because:

(Attach additional sheets if you need more space)

PLEASE ATTACH A COPY OF THE ADMINISTRATIVE LAW JUDGE DECISION OR DISMISSAL ORDER YOU ARE APPEALING.

If you have additional evidence, submit it with this request for review. If you need more time to submit evidence or legal argument, you must request an extension of time in writing now, explaining the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Medicare Appeals Council grants, the Medicare Appeals Council will take action based on the evidence of record.

IMPORTANT: Include the HICN or Docket Number on any letter or other material you submit.

(CONTINUED ON PAGE 2)

10. This request must be received or postmarked within 60 days of the date of receipt of the Administrative Law Judge's decision or dismissal order, unless the time limit is extended for good cause. The date of receipt is presumed to be 5 days after the date the decision or dismissal order was issued, absent evidence to the contrary. If this request will not be received or postmarked within 65 days of the date the decision or dismissal order was issued, please explain the reason(s) below or in an attachment to this request:

DATE			DATE		
APPELLANT'S SIGNATURE (the party requesting review)			REPRESENTATIVE'S SIGNATURE		
PRINT NAME			PRINT NAME		
ADDRESS			ADDRESS		
CITY, STATE, ZIP CODE			CITY, STATE, ZIP CODE		
TELEPHONE NUMBER	FAX NUMBER	E-MAIL	TELEPHONE NUMBER	FAX NUMBER	E-MAIL

THE RECEIVING OFFICE WILL COMPLETE THIS PART

Request received on _____ by: _____
(Date) (Print Name and Title)

at:

(Office Where Filed)

Check all claim types that apply:

☐ Medicare – Part A ☐ Medicare – Part B ☐ Medicare + Choice ☐ Other

The party filing this request or the office receiving it should mail the request, with any attachments, to:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, S.W., Room G-644
Washington, D.C. 20201

PRIVACY ACT STATEMENT

The collection of information on this form is authorized by the Social Security Act (section 205(a) of title II, section 702 of title VII, section 1155 of Title XI, and sections 1852(g)(5), 1869(b)(1), 1871, 1872, and 1876(c)(5)B) of title XVIII, as appropriate). The information provided will be used to further document your claim. 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 claim. Information you furnish on this form may be disclosed by the Department of Health and Human Services or the Social Security Administration to another person or governmental agency only with respect to programs under the Social Security Act and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services, the Social Security Administration, or other agencies.