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

Form Approved
OMB No. 0938-0045

REQUEST FOR RECONSIDERATION OF PART A HEALTH INSURANCE BENEFITS

INSTRUCTIONS: *Please type or print firmly*. Leave the block empty if you cannot answer it. Take or mail the WHOLE form to your Social Security office which will be glad to help you. Please read the statement on the reverse side of page 2.

1. Beneficiary's Name

2. Health Insurance Claim Number

3. Representative's Name, if applicable

☐ Relative ☐ Attorney ☐ Other Person ☐ Provider Filing

4. PLEASE ATTACH A COPY OF THE NOTICE(S) YOU RECEIVED ABOUT YOUR CLAIM TO THIS FORM.

5. This Claim is for

☐ Inpatient Hospital ☐ Skilled Nursing Facility (SNF) ☐ Health Maintenance Organization (HMO)
☐ Emergency Hospital ☐ Home Health Agency (HHA)

6. Name and Address of Provider *(Hospital, SNF, HHA, HMO)*

City and State

Provider Number

7. Name of Intermediary

City and State

Intermediary Number

8. Date of Admission or Start of Services

9. Date(s) of the Notices You Received

10. I do not agree with the determination of my claim. Please reconsider my claim because

11. You must obtain any evidence *(for example, a letter from a doctor) you* wish to submit

☐ I have attached the following evidence

☐ I will send this evidence within 10 days

☐ I have no additional evidence or other information to submit with my claim

12. Is this request filed within 120 days of the date of your notice?

☐ Yes ☐ No

If you checked "No," attach an explanation of the reason for the delay to this form.

13. Only one signature is needed. This form is signed by

☐ Beneficiary ☐ Representative ☐ Provider Rep.

SIGN HERE ▶

14. Street Address

City, State, Zip Code

Telephone

Date

15. If this request is signed by mark (X). TWO WITNESSES who know the person requesting reconsideration must sign in the space provided on the reverse side of this page of the form.

DO NOT FILL IN BELOW THIS LINE — FOR SOCIAL SECURITY USE — THANK YOU

16. Routing

☐ Intermediary

☐ CMS, RO-Medicare

☐ BSS, ODR

17. Additional Information

18. SSA or Intermediary Date Stamp

15A. Witnesses are required ONLY if this request has been signed by mark (X) on the reverse side of this page. If signed by mark (X), two witnesses to the signing who know the person requesting the reconsideration must sign below, giving their full addresses.

15.B. Signature of Witness	15.C. Signature of Witness
Address	Address
City, State, Zip Code	City, State, Zip Code

"This information is needed in administering the Medicare program. Social Security's authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended. It is used to identify your claim and medical services you received to properly route, process, and protect your claim appeal review request and rights. The information may be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to process your request for reconsideration appeal review of the final determination made on your claim for benefits.

With one exception (discussed below), there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services you received would delay or prevent processing your appeal for reconsideration for benefit payment for these services.

The exception noted above, is that it is mandatory that you advise us if you are being treated for a work related injury so we can determine whether Workmen's Compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information."