RECONSIDERATION REQUEST FORM

Redetermination Number:

Contractor #: 17013, CGS, DME MAC - B

DIRECTIONS: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/ include information for items 1, 2a, 6, 7, 11 & 12, but to help us serve you better, please include a copy of the redetermination notice with your request.

C2C Innovative Solutions, Inc.
ATTN: DME QIC
PO Box 44013
Jacksonville, Florida 32231-4013

1. Name of Beneficiary:
2a. Medicare Number:
2b. Claim Number (ICN/DCN, If Available):
3. Provider Name:
4. Person Appealing: Beneficiary Provider of Service Representative
5. Address of Person Appealing:
5a. Telephone Number of the Person Appealing:
5b. E-mail Address of the Person Appealing:
6. Item or Service You Wish To Appeal:
7. Date of Service: From To
8. Does This Appeal Involve an Overpayment? Yes No
9. Why Do You Disagree? Or What Are Your Reasons For Your Appeal? (Attach additional pages, if necessary.)

10. Do You Have Any Supporting Material to Assist Your Appeal? *Example: Medical Records, Office Records/Progress Notes, CMN*

11. Printed Name of Person Appealing:
12. Signature of Person Appealing: DATE:

Originated July 5, 2016.

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