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Healthcare Solutions

Reconsideration Request Form

Redetermination/Appeals
Number: _____

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. Items 1, 2, 6a, 6b, 10, & 11 are mandatory; but to help us serve you better, please include a copy of the redetermination notice and complete the information below.

C2C Innovative Solutions, Inc.
QIC DME
PO Box 44013
Jacksonville, FL 32231-4013

1. Name of Beneficiary: _____
2. Medicare Number: _____
3. Provider/Supplier Name and Number (PTAN): _____
4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative of Service
5. Address of the Person Appealing: _____
6. Item or service you wish to appeal:

6a. Date of Service(s)	6b. Description of the Item/Service You wish to Appeals (for example, Procedure Code/DRG)	6c. Claim Number(s)

7. Does this appeal involve an overpayment? ☐ Yes ☐ No
   Recovery Auditor? ☐ Yes ☐ No
8. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary): _____
9. You may also include any supporting material to assist your appeal. Examples of supporting materials include: _____
   - Medical Records
   - Copy of the Claim
   - Certificate of Medical Necessity
   - Office Records/Progress Notes
   - Treatment Plan
   - Redetermination Notice
10. **Printed Name of Person Appealing:** _____ **Phone:** _____
11. Signature of Person Appealing: _____ Date: ___ / ___ / _____
12. Medicare Administrative Contractor (MAC) Number 19003