

MEDICARE REDETERMINATION 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 initial determination notice _____
(If you received your initial determination notice more than 120 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.

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