# SETTLEMENT CONFERENCE FACILITATION (SCF) EXPRESSION OF INTEREST

## Medicare Part B Administrative Law Judge Appeals

To formally request OMHA Settlement Conference Facilitation, you must first receive an OMHA *Settlement Conference Facilitation Preliminary Notice*. If you have not received this notice, and wish to initiate the process yourself, you must complete this *Settlement Conference Facilitation Expression of Interest* form to request that OMHA produce the Preliminary Notice.

You may e-mail this completed form in PDF format to OMHA.SCF@hhs.gov. OMHA cannot accept electronic signatures at this time. Please scan your Expression of Interest form, with original signature, into PDF format and then send it as an attachment.

If you are a provider or supplier who is interested in Settlement Conference Facilitation (SCF) for Medicare Part A and Medicare Part B appeals, please complete this form and the Part A *Expression of Interest* form and submit both forms together in one email.

You must not email any beneficiary personally identifiable information including beneficiary first or last names, beneficiary names represented by initials, beneficiary addresses, or truncated health insurance claim numbers (HICN). You must only provide the information requested in this form. Failure to protect beneficiaries' private data will result in rejection of your appeals from the SCF process.

For more information on the OMHA SCF process, please visit the OMHA website at www.hhs.gov/omha or contact us at OMHA.SCF@hhs.gov.

**Appellant Name** (the provider or supplier that appealed the QIC reconsideration):

*Please note, if you are a Medicare beneficiary or a Medicaid State Agency, your claim appeals are not currently eligible for the OMHA Settlement Conference Facilitation process.*

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| Appellant point of contact (not necessary if represented) | | Representative name (if applicable) (must be an individual) | |
| E-mail Address: | | E-mail Address: | |
| Point of Contact Title (not necessary if represented) | | Representative firm or business (if applicable) | |
| Address | | Address | |
| City State Zip Code | | City State Zip Code | |
| Phone Number (extension #, if any) | Fax Number | Phone Number (extension #, if any) | Fax Number |

Medicare Part B National Provider Identifier (NPI) and corresponding Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN). If claims were submitted under multiple identification numbers, list all of the identification numbers at issue.

Please **do not** handwrite NPI, PTAN, or CCN numbers. If you need additional space, please attach in a separate document:

| **NPI** | **PTAN or CCN** |
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Indicate whether the appealed claims pending are pre-payment denials, post-payment denials, or both:

☐ Pre-Payment ☐ Post-Payment

Has the appellant filed for bankruptcy and/or is expected to file for bankruptcy in the future? If yes, the appellant is not eligible for SCF.

☐ YES ☐ NO

I am requesting that OMHA initiate the SCF process for my appeals that are pending an Administrative Law Judge hearing. I understand that OMHA will review the appeals that I have pending and determine, to the best of its ability, which appeals would be eligible for SCF, if any.

I understand that this Expression of Interest serves only to initiate the settlement conference process. This Expression of Interest is not my formal request for SCF. I further understand that I cannot formally request SCF until I receive an *SCF Preliminary Notification* from OMHA. I understand that the Centers for Medicare & Medicaid Services (CMS) are not obligated to enter into a settlement agreement with me. I also understand that any party may respectfully decline participation in the SCF process at any time.

I am authorized to initiate the SCF process on behalf of the appellant identified above. I attest that the information provided in this form is true and correct to the best of my knowledge.

| Appellant Signature | Appellant Printed Name | Date |
|---|---|---|
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