



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

**REQUEST FOR ADMINISTRATIVE LAW JUDGE (ALJ) TO
REVIEW DISMISSAL BY THE QUALIFIED INDEPENDENT CONTRACTOR**

☐ **PART A**

☐ **PART B**

Effective July 1, 2005. For use by a party to a dismissal issued by a Qualified Independent Contractor (QIC).
(The remaining amount in controversy must be \$100 or more.)

Please send copies of this completed form to:

Original: Office of Medicare Hearings and Appeals specified in the QIC dismissal notice; **Copy:** Appellant

APPEALING PARTY INFORMATION

Appellant Name <i>(The party appealing the QIC's dismissal)</i>		Health Insurance Claim (HIC) Number	
Street	City	State	ZIP Code
Telephone Number	Alternate Telephone Number	E-Mail	

BENEFICIARY INFORMATION

Beneficiary Name <i>(Leave blank if same as the appellant)</i>		Health Insurance Claim (HIC) Number	
Street	City	State	ZIP Code
Telephone Number	Alternate Telephone Number	E-Mail	

PROVIDER OR SUPPLIER INFORMATION

Provider or Supplier <i>(Leave blank if same as the appellant)</i>			
Street	City	State	ZIP Code
Telephone Number	Alternate Telephone Number	E-Mail	

CMS CONTRACTOR INFORMATION

QIC that dismissed your Medicare case	Document Control Number assigned by the QIC	Dates of Service	
		From:	To:

I request that an Administrative Law Judge (ALJ) review the QIC's dismissal of the appeal.
(Attach a continuation sheet if you require additional space)

I disagree with the dismissal because:

Answer the following questions that apply:

A. Does request involve multiple claims?

(If yes, a list of claims must be attached.)

☐ Yes ☐ No

B. Does request involve multiple beneficiaries?

(If yes, a list of beneficiaries, their HICNs, and the dates of service must be attached.)

☐ Yes ☐ No

C. Did the beneficiary assign his or her appeal rights to you as the provider/supplier?

(If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment).

☐ Yes ☐ No

REPRESENTATIVE INFORMATION

You have a right to be represented. If you are not represented, but would like to be, contact the Office of Medicare Hearings and Appeals Field Office assigned to your appeal for a list of legal referral and service organizations. If you are represented, and have not already done so, you must complete form CMS-1696 located at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf>.

If you have a representative, please complete the following information: **Please check one:** ☐ Attorney ☐ Non-Attorney

Representative Name

Street	City	State	ZIP Code
Telephone Number		E-Mail	

EVIDENCE

Please check one: ☐ I have additional evidence to submit ☐ I have no additional evidence submit

If you have additional evidence to submit, please attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it.

Appellant's or Appellant's Representative's Name

Appellant's or Appellant's Representative's Signature	Date
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PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(I), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS**Is this request timely filed?** ☐ Yes ☐ No

If no, attach appellant's explanation for delay. If there is no explanation, send a Notice of Late Filing of Request for ALJ Hearing to the appellant and representative, if applicable, to request such an explanation.

Request received on:

Field Office:

Employee:

Assigned on:

Assigned by:

Assigned to:

Special Response Case? ☐ Yes ☐ No

If yes, explain why and state the targeted adjudication deadline.

Interpreter/translator needed (including sign language)? ☐ Yes ☐ No

If Yes, type needed: _____

If appellant is not represented, has a list of legal referral and service organizations been provided? ☐ Yes ☐ No