



How to File a Medicare Part A or Part B Appeal in Original Medicare

Original Medicare includes Part A (Hospital Insurance) and Part B (Medical Insurance). Original Medicare covers certain medical services and items in hospitals and other settings.

If you have Original Medicare, you can file an appeal in the following situations:

- A service or item you got isn't covered and you think it should be
- Payment for a service or item is denied and you think Medicare should pay for it
- You question the amount that Medicare paid for a service or item

Your appeal rights are explained on the back of the Medicare Summary Notice (MSN). You get this notice every 3 months from the company that handles bills for Medicare. The MSN will list all the services and items that were billed to Medicare during the 3-month period and will tell you if Medicare paid for the services or items. The MSN will also tell you why Medicare won't pay for the item or service and how to file an appeal. If you file an appeal, ask your doctor or health care provider for any information that might help your case.

Note: If you are enrolled in a Medicare Advantage Plan (like an HMO or PPO), your appeal rights are described in your plan's materials.

The Appeals Process

There are five levels in the Part A and Part B appeals process:

1. Redetermination by the company that handles bills for Medicare
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearing by an Administrative Law Judge (ALJ)
4. Review by the Medicare Appeals Council (MAC)
5. Federal District Court Review



First Level of Appeal: Redetermination

Your MSN tells you if Medicare has paid your medical claim or denied it. This is the initial determination, which is made by people at the company that handles your bills for Medicare. If you don't agree with this determination, you may request a redetermination. A redetermination is when the claim is reviewed by people at the company who are different from the people who made the initial determination.

- You must file a request for redetermination within 120 days of when you got the MSN.
- You can use the MSN to make your request.
- You can request a redetermination for a claim of any amount of money.
- In most cases, the company that handles your bills for Medicare will send you a written decision within 60 days of getting your request.

How to Request a Redetermination

You can request a redetermination in one of three ways:

1. Follow the instructions on your MSN:
 - Circle the items that you don't agree with.
 - Explain why you don't agree.
 - Sign, write your telephone number, and provide your Medicare number on the MSN. You may want to keep a copy for your records.
 - Send it to the company that handles your bills for Medicare identified in the "Appeal Information" section of the MSN.

OR (see next page)



First Level of Appeal: Redetermination (continued)

2. Use the “Medicare Redetermination Request Form” (Form CMS–20027) by visiting www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf. Send it to the company that handles your bills for Medicare.

OR

3. Send a letter to the company that handles your bills for Medicare. Your letter must include the following:
 - Your name.
 - Your Medicare number (located on your red, white, and blue Medicare card).
 - The specific service(s) and/or item(s) for which you’re requesting a redetermination.
 - An explanation of why you don’t agree with the initial determination.
 - The date(s) of service.
 - Your signature or the name and signature of your appointed representative. You can get an “Appointment of Representative” form (Form CMS-1696) by visiting www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.

No matter how you choose to request a redetermination, you must send it to the company that handles your bills for Medicare. This company is identified on your MSN. You also should send any documents that you believe may help your case. For example, you should include copies of your medical bills, copies of related MSNs, and any information you get from your doctor. You may want to keep a copy of your request for your records.



Second Level of Appeal: Reconsideration

If you aren't satisfied with the redetermination decision, you may request a reconsideration. A Qualified Independent Contractor (QIC) that didn't take part in the redetermination will make the reconsideration decision.

- You must file the request for reconsideration with the appropriate QIC within 180 days of when you got the redetermination. Your redetermination notice will have detailed information about how to file for a reconsideration.
- You can request a reconsideration for a claim of any amount of money.
- In most cases, the QIC will send you a written reconsideration within 60 days of getting your request. If the QIC can't issue a timely decision, you may ask to skip to the next level of appeal. See page 5.

How to Request a Reconsideration

You can request a reconsideration in one of two ways:

1. Use the "Medicare Reconsideration Request Form" (Form CMS-20033), which will be included with the Medicare Redetermination Notice. The form is also available at www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf. Send it to the QIC that will handle your reconsideration.

OR

2. Send a letter to the QIC that will handle your reconsideration. Your letter must include the following:
 - Your name.
 - Your Medicare number (located on your red, white, and blue Medicare card).
 - The specific service(s) and/or item(s) for which you're requesting a reconsideration.
 - The date(s) of service.
 - Your signature or the name and signature of your appointed representative. You can get an "Appointment of Representative" form (Form CMS-1696) by visiting www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
 - The name of the company that made the redetermination (the company that handled your bill for Medicare), which you can find on the MSN and on the Medicare Redetermination Notice.

The reconsideration request should clearly explain why you don't agree with the redetermination. Send a copy of the Medicare Redetermination Notice with your request for a reconsideration to the QIC. You should also send with your reconsideration request any documents that you believe may help your case. If you send documents after the reconsideration request has been filed, it may take longer for the QIC to make a decision. Also, you may want to keep a copy of your request for your records.



Third Level of Appeal: Administrative Law Judge (ALJ) Hearing

If you aren't satisfied with the QIC's reconsideration decision, you may appeal to an ALJ.

- You must file the request for a hearing with an ALJ within 60 days of when you got the reconsideration decision.
- The claim(s) in your appeal must satisfy a minimum dollar amount to get an ALJ hearing. In the reconsideration letter, the QIC will provide a statement of whether your case satisfies this requirement. However, it's up to the ALJ to make the final decision.
- The ALJ will generally send you a written decision within 90 days of getting your request. If the ALJ can't issue a timely decision, you may ask the ALJ to skip to the next level of appeal.

How to Request an ALJ Hearing

To request an ALJ hearing, follow the instructions in the reconsideration letter you received from the QIC. You can find more information on the ALJ hearing process by visiting www.hhs.gov/omha. Select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Fourth Level of Appeal: Medicare Appeals Council (MAC) Review

If you don't agree with the ALJ's decision, you may file an appeal with the MAC.

- You must submit the request for MAC review in writing within 60 days of when you got the ALJ's decision.
- You can request MAC review for a claim of any amount of money.
- The MAC will generally send you a written decision within 90 days of getting your request. If the MAC can't issue a timely decision, you may ask the MAC to skip to the next level of appeal. See page 6.

How to Request a MAC Review

Refer to the ALJ's decision for instructions on filing a request for MAC review.



Fifth Level of Appeal: Federal District Court Review

If you don't agree with the MAC's decision, you may file an appeal in Federal District court.

- The claim(s) in your appeal must satisfy a minimum dollar amount to get Federal District court review.
- You must file your request in Federal District Court within 60 days of when you got the MAC's decision.

How to Request a Federal District Court Review

Refer to the MAC's decision for instructions on requesting Federal District court review.

For More Information

- Visit www.medicare.gov, and select "Medicare Appeals."
- Visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet "Your Medicare Rights and Protections."
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. To get the telephone number for the SHIP in your state, visit www.medicare.gov, and select "Find Helpful Phone Numbers and Websites." Or, call 1-800-MEDICARE.