

## WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Puerto Rico

## **Reconsideration Request Form**

**Directions**: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, and 11 but to help us serve you better; please include a copy of the redetermination notice with your request.

Submit requests to: C2C Innovative Solutions Inc.

QIC Part B South P.O. Box 45300

Jacksonville, FL 32232-5300

1. Name of Beneficiary:				
2a. Medicare ID:				
2b. Claim Number (ICN/DCN if available):				
3. Provider Name:				
4. Person Appealing:	Beneficiary	Provider of Service	Representative	
5. Address of the Person Appealing:	Address			
	City	State	ZIP Code	
5a. Telephone Number of the Person Appealing:				
5b. Email Address of the Person Appealing:				
6. Item or service you wish to appeal:				
7. Date of the service:	From	To		
8. Does this appeal involve an overpayment?	Yes	No		



Please include a copy of the demand letter with your request.

9. Why do you disagree? Or who	at are your reasons for appeal? (	255 character limit; attach additional pages if necessary.)	
10. You may also include any su	upporting materials to assist your	appeal. Examples of supporting materials include:	
Medical Records	Office Records/Progress N	otes Copy of the Claim	
Treatment Plan	Certification of Medical Nec	Certification of Medical Necessity	
11. Printed Name of Person App	pealing:		
Contractor Number	R	Redetermination Number	



09202