



WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

U.S. Virgin Islands

Form revised 10/1/2019

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, 11, & 12 but to help us serve you better; please include a copy of the redetermination notice with your reconsideration request.

Submit requests to: C2C Innovative Solutions, Inc.
QIC Part A East Appeals
P.O. Box 45305
Jacksonville, FL 32232-5305

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 what are your reasons for appeal? (255 character limit; attach additional pages if necessary.)

10. You may also include any supporting materials to assist your appeal. Examples of supporting materials include:

Medical Records

Office Records/Progress Notes

Copy of the Claim

Treatment Plan

Certification of Medical Necessity

11. Printed Name of Person Appealing:

Date:

Contractor Number 09201	Redetermination Number
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Reconsideration request

Version 9