FIRST COAST SERVICE OPTIONS, INC.

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, 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 Number:_____

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

Contractor Number **09302**	Redetermination Number

Print **Reset**