Florida

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:

Contractor Number	Redetermination Number
09101	

Reconsideration request Version 9

Print **Reset**