DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

REQUEST FOR ESCALATION TO MEDICARE APPEALS COUNCIL

Instructions: This form may be used by the appellant in a Medicare Part A or Part B appeal of a Qualified Independent Contractor (QIC) reconsideration that is pending at the Office of Medicare Hearings and Appeals (OMHA) to request escalation of the appeal to the Medicare Appeals Council, provided that the appellant filed a timely request for hearing; the adjudication period, including any extensions, has expired; and the appellant did not waive the adjudication period.

If your request meets these requirements, and OMHA is not able to issue a decision, dismissal, or remand within the later of five calendar days of receiving this request for escalation, or five calendar days from the end of the applicable adjudication period, your appeal will be escalated to the Medicare Appeals Council for review. Escalation is not available for a QIC dismissal of a request for reconsideration.

To request escalation, complete this form and send it to the assigned OMHA adjudicator or, if an adjudicator has not yet been assigned, to: OMHA Central Operations, Attention: Escalation Request Mail Stop, 1001 Lakeside Ave., Suite 930, Cleveland, OH 44114-1158. You must also send a copy of this request for escalation to the other parties who were sent a copy of the reconsideration decision in your appeal.

Section 1: What is the appeal information?

OMHA Appeal Number *(if known)*	Reconsideration Number (*if OMHA appeal number not known*)
Appellant Name	Assigned OMHA Adjudicator *(if known)*

Section 2: What is the requestor's Information

Name *(First, Middle initial, Last)*	Firm or Organization *(if applicable)*		
Mailing Address	City	State	ZIP Code
E-Mail	Telephone Number	Fax Number	

Type of Requestor: ☐ Appellant ☐ Representative

If you are a representative, have you filed an appointment of representative (CMS-1696) or other documents authorizing the representation?

☐ N/A ☐ Yes ☐ No (*Please file the document(s) with this request.*)

Section 3: Acknowledge the following by signing and dating below:

- I certify that the request for hearing in the appeal identified in section 1 was timely filed; the applicable adjudication period, including any extensions, has expired; and I have not waived the adjudication period.
- I understand that if my appeal is escalated to the Medicare Appeals Council, OMHA will not issue a decision in this appeal and the QIC reconsideration decision will be the decision that is subject to review by the Medicare Appeals Council.
- I certify that I am sending a copy of this request for escalation to the parties who were sent a copy of the reconsideration decision.

Signature	Date

Privacy Act Statement

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

If you need large print or assistance, please call 1-855-556-8475