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

REQUEST FOR SETTLEMENT CONFERENCE FACILITATION

To request OMHA Settlement Conference Facilitation (SCF) for OMHA and/or Medicare Appeals Council (Council) appeals, you must complete this document, including the appellant name in the first box below, and submit it via e-mail. Failure to properly complete this document will result in rejection of your *Request for SCF*. Please note, handwritten/wet signatures and digital/electronic signatures will be accepted.

Please scan or save your Request for SCF into a PDF document and e-mail your request to OMHA_SCFAppeals@cms.hhs.gov.

For more information on the OMHA SCF process, please visit the OMHA website at www.hhs.gov/omha or contact us at OMHA.SCF@hhs.gov.

Appellant Name *(the provider or supplier that appealed the QIC reconsideration)*

Please note, if you are a Medicare beneficiary or a Medicaid State Agency, your claim appeals are ineligible for the OMHA SCF Request process.

Appellant Point of Contact *(not necessary if represented)*			Representative/Attorney name *(if applicable) (must be an individual)*		
Point of Contact Title *(not necessary if represented)*			Representative Firm or Business *(if applicable)*		
E-mail Address			E-mail Address		
Street Address			Street Address		
City	State	ZIP Code	City	State	ZIP Code
Phone Number *(extension #, if any)*	Fax Number		Phone Number *(extension #, if any)*	Fax Number	

National Provider Identifier (NPI) and corresponding Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN). If claims were submitted under multiple identification numbers, list all of the identification numbers at issue.

Please **do not** handwrite NPI and PTAN/CCN numbers. OMHA will not accept handwritten NPI or PTAN/CCN numbers. If you need additional space, please attach in a separate document:

NPI	PTAN or CCN

Indicate whether claims are pre-payment and/or post-payment denials *(please check both boxes, if both options apply):*

☐ Pre-Payment Denial ☐ Post-Payment Denial

Were all claims covered under Medicare Part A and/or Medicare Part B *(please check both boxes, if both options apply)*?

☐ Part A ☐ Part B

Were all of your requests for ALJ hearing or Council review timely filed *(e.g., ALJ requests for hearing must be filed within 60 days of receiving the QIC reconsideration notice)*?	☐ Yes	☐ No
Is the amount in controversy (AIC) met for all of your appeals? For the following calendar years (CY), the AIC is as follows (CY/AIC): CY 2013–CY 2014/$140; CY 2015–CY 2016/$150; CY 2017–CY 2019/$160; CY 2020/$170.	☐ Yes	☐ No
Currently, are all of your requests for ALJ hearing unscheduled for an ALJ hearing *(that is, you have <u>not</u> received a Notice of Hearing)*?	☐ Yes	☐ No

NOTE: If any of the above responses are marked "<u>No</u>," then some of your appeals may be ineligible for SCF. Your Preliminary Notification will state the reason(s) why some appeals will not be included in SCF.

Are any of your appeals contesting a Qualified Independent Contractor (QIC) or ALJ dismissal order?	☐ Yes	☐ No
Do you know of any False Claims Act litigation or investigations pending against you or your organization?	☐ Yes	☐ No
Has the Appellant executed a settlement agreement with the United States related to False Claims Act litigation or related conduct since January 1, 2010?	☐ Yes	☐ No
Do you have a pending bankruptcy filing and/or is the appellant expected to file for bankruptcy in the future?	☐ Yes	☐ No
Do any of the appealed claim(s) involve equipment, items, services, drugs, or biologicals billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes *(for example, HCPCS Code J3490 Unclassified drugs; HCPCS Code K0108 Wheelchair component or accessory, not otherwise specified)*?	☐ Yes	☐ No

NOTE: If any of the above responses are marked "<u>Yes</u>," then some of your appeals may be ineligible for SCF. Your Preliminary Notification will state the reason(s) why some appeals will not be included in SCF.

I am requesting the SCF process for my appeals that are pending an OMHA or Council review. I understand that my appeals will be reviewed to determine what I have pending and determine which appeals will be eligible for SCF, if any. Notwithstanding, I understand it is solely my responsibility to ensure that my appeals subject to SCF actually meet all of the SCF eligibility criteria.

I understand that once my SCF eligible appeals are identified and confirmed, my SCF eligible appeals will be placed in a hold status during the entirety of the SCF process. This means my appeals will not be processed for OMHA or Council assignment, hearing, and/or decision or order until after the SCF process has concluded. I also understand that if an agreement is not reached, my appeals will return to the OMHA or Council dockets in the order in which my request(s) for review was received.

I understand that the Centers for Medicare & Medicaid Services (CMS) is not obligated to enter into a settlement agreement with me. I also understand that any party may decline participation in the SCF process at any time. I understand I do not have the right to appeal CMS' declination to participate in SCF with me. Further, I understand that the U.S. Department of Justice must approve a proposed settlement agreement involving individual appealed claims with billed charges in excess of $100,000 or an appeal of an extrapolated overpayment with an overpayment demand amount in excess of $100,000.

I am authorized to initiate the SCF process on behalf of the appellant identified above. I attest that the information provided in this document is true and correct to the best of my knowledge.

Appellant Signature	Appellant Printed Name	Date