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

REQUEST FOR ADMINISTRATIVE LAW JUDGE (ALJ) HEARING OR REVIEW OF DISMISSAL

Section 1: Which Medicare Part are you appealing (if known)? (*Check one*)

☐ Part A ☐ Part B ☐ Part C (*Medicare Advantage*) or Medicare Cost Plan ☐ Part D (*Prescription Drug Plan*)

Section 2: Which party are you, or which party are you representing? (*Check one*)

☐ The Medicare beneficiary or enrollee, or a successor (such as an estate), who received or requested the items or services being appealed, or is appealing a Medicare Secondary Payer issue.

☐ The provider or supplier that furnished the items or services to the Medicare beneficiary or enrollee, a Medicaid State agency, or an applicable plan appealing a Medicare Secondary Payer issue.

☐ Other. *Please explain*:

Section 3: What is your (the appealing party's) information?

(*Representative information in next section*)

Name (*First, Middle Initial, Last*)		Firm or Organization (*if applicable*)		
Address where appeals correspondence should be sent	City		State	ZIP Code
Telephone Number	Fax Number	E-Mail		

Section 4: What is the representative's information?

(*Skip if you do not have a representative*)

Name		Firm or Organization (if applicable)		
Mailing Address	City		State	ZIP Code
Telephone Number	Fax Number	E-Mail		

Section 4: What is the representative's information? *(Continued)*

Did you file an appointment of representation (form CMS-1696) or other documents authorizing your representation at a prior level of appeal?	☐ No. *Please file the document(s) with this request.* ☐ Yes

Section 5: What is being appealed? *Submit a separate request for each Reconsideration or Dismissal that you wish to appeal. If the appeal involves multiple beneficiaries or enrollees, use the multiple claim attachment (OMHA-100A).*

Name or entity that issued the Reconsideration *or Dismissal* (*or attach a copy of the Reconsideration or Dismissal*)		Reconsideration (Medicare Appeal or Case) Number (*or attach a copy of the Reconsideration or Dismissal*)	
Beneficiary or Enrollee Name		Health Insurance Claim Number	
Beneficiary or Enrollee Mailing Address	City	State	ZIP Code
What item(s) or service(s) are you appealing? (*N/A if appealing a Dismissal*)		Date(s) of service being appealed (*if applicable*)	

Section 5: What is being appealed? *(Continued)*

Supplier or Provider Name (*N/A for Part D appeals*)	Supplier or Provider Telephone Number (*N/A for Part D appeals*)		
Supplier or Provider Mailing Address (*N/A for Part D appeals*)	City	State	ZIP Code

Section 6: For appeals of prescription drugs ONLY (*Skip for all other appeals*)

Part D Prescription Drug Plan Name	What drug(s) are you appealing?

Are you requesting an expedited hearing? (*An expedited hearing is only available if your appeal is not solely related to payment (for example, you do not have the drug) and applying the standard time frame for a decision (90 days) may jeopardize your health, life, or ability to regain maximum function*)

☐ No. ☐ Yes. *On a separate sheet, please explain or have your prescriber explain why applying the standard time frame for a decision (90 days) may jeopardize your health, life, or ability to regain maximum function.*

Section 7: Why do you disagree with the Reconsideration or Dismissal being appealed?

(*Attach a continuation sheet if necessary*)

Section 8: Are you submitting evidence with this request, or do you plan to submit evidence?

☐ I am not planning to submit evidence at this time. (*Skip to Section 9, below*)

☐ I am submitting evidence with this request.

☐ I plan to submit evidence. Indicate what you plan to submit and when you plan to submit it:

Was the evidence already submitted for the matter that you are appealing?

☐ No. *Part A and Part B appeals only. If you are a provider or supplier, or a provider or supplier that is representing a beneficiary, you must include a statement explaining why the evidence is being submitted for the first time and was not submitted previously.*

☐ Yes.

Section 9: Is there other information about your appeal that we should know?

Are you aggregating claims to meet the amount in controversy requirement? (*If yes, attach your aggregation request. See 42 C.F.R. § 405.1006(e) and (f), and 423.1970(c) for request requirements.*)	☐ No	☐ Yes
Are you waiving the oral hearing before an ALJ and requesting a decision based on the record? (*If yes, attach a completed form OMHA-104 or other explanation. N/A if requesting review of a dismissal.*)	☐ No	☐ Yes
Does the request involve claims that were part of a statistical sample? (*If yes, please explain the status of any appeals for claims in the sample that are not included in this request.*)	☐ No	☐ Yes

Section 10: Certification of copies sent to other parties (*Part A and Part B appeals only*)

If another party to the claim or issue that you are appealing was sent a copy of the Reconsideration or Dismissal, you must send a copy of your request for an ALJ hearing or review of dismissal to that party.

Indicate the party (or their representative) to whom and address where you are sending a copy of the request, and when the copy will be sent *(attach a continuation sheet if there are multiple parties)*.

Name of Recipient		
Mailing Address		
City	State	ZIP Code
Date of Mailing		

☐ Check here if no other parties were sent a copy of the Reconsideration or Dismissal.

Section 11: Filing instructions

Your appealed claim must meet the current amount in controversy requirement to file an appeal. See the Reconsideration or Dismissal or visit www.hhs.gov/omha for information on the current amount in controversy. Send this request form to the entity in the appeal instructions that came with your reconsideration (for example, requests for hearing following a Part C reconsideration are generally sent to the entity that conducted the reconsideration). If instructed to send to OMHA, use the addresses below.

Section 11: Filing instructions *(Continued)*

Beneficiaries and enrollees, send your request to:	**For expedited Part D appeals, send your request to:**	**All other appellants, send your request to:**
OMHA Central Operations Attn: Beneficiary Mail Stop 1001 Lakeside Ave., Suite 930 Cleveland, Ohio 44114-1158	OMHA Central Operations Attn: Expedited Part D Mail Stop 1001 Lakeside Ave., Suite 930 Cleveland, Ohio 44114-1158	OMHA Central Operatons 1001 Lakeside Ave., Suite 930 Cleveland, Ohio 44114-1158

We must receive this request within 60 calendar days after you received the Reconsideration or Dismissal that you are appealing. We will assume that you received the Reconsideration or Dismissal 5 calendar days after the date of the Reconsideration or Dismissal, unless you provide evidence to the contrary. *If you are filing this request late, attach a completed form OMHA-103 or other explanation for the late filing*.

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