

## MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: \_\_\_\_\_
2. Medicare Number: \_\_\_\_\_
3. Description of Item or Service in Question: \_\_\_\_\_
4. Date the Service or Item was Received: \_\_\_\_\_
5. I do not agree with the determination of my claim. MY REASONS ARE:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Date of the initial determination notice \_\_\_\_\_  
*(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Additional Information Medicare Should Consider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Requester's Name: \_\_\_\_\_
9. Requester's Relationship to the Beneficiary: \_\_\_\_\_
10. Requester's Address: \_\_\_\_\_  
\_\_\_\_\_
11. Requester's Telephone Number: \_\_\_\_\_
12. Requester's Signature: \_\_\_\_\_
13. Date Signed: \_\_\_\_\_
14.  I have evidence to submit. (Attach such evidence to this form.)  
 I do not have evidence to submit.

**NOTICE:** Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.