Tutorial: How to complete the Medicare reconsideration request form (CMS-20033)

This tutorial has been created to assist you in completing the [Medicare Reconsideration Request Form (CMS-20033)](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS020393.html).

The Medicare reconsideration request form should be used if you disagree with the redetermination decision. You will need to mail the completed, signed form to the qualified independent contractor (QIC). The name and mailing address for the QIC can be found in your redetermination letter along with a reconsideration request form (the form sent with your letter is slightly different than the CMS-2003 form.)

Note: Mail the reconsideration request form to the QIC only. Do not send to Novitas Solutions. Mailing your request for reconsideration to Novitas Solutions will cause unnecessary delays.

A request for reconsideration must be received at the QIC within 180 days from the date of receipt of the redetermination notice. For help in determining the date for timely appeal filing, please use the [Appeals Processing Time Frame Calculator](ddocname:00002659).

If you choose not to use this form, your letter must include:

* Name of the beneficiary
* Medicare number
* Your name and contact information
* List of the service(s) or item(s) you are appealing and date(s) of service
* Any supporting evidence
* Contractor name that completed the redetermination

The Centers for Medicare & Medicaid Services (CMS) has established certain required information which must be submitted in order for the QICs to complete the reconsideration. Failure to provide this required information will result in delays in handling your reconsideration request.

Completing all fields on this form will ensure you meet the CMS minimum requirements for requesting the reconsideration.

Each section of the reconsideration request form is outlined below:

Block 1 - Beneficiary name: Include the first and last name of the beneficiary as it appears on the Medicare card.

Block 2 - Medicare number: Include the beneficiary's complete Medicare number as found on their Medicare card.

Block 3 - Item or service you wish to appeal: Provide a complete description of the item or service in question.

Block 4 - Date of service: From / To  
Block 5 - Date of the redetermination notice: Please include a copy of the notice with this request

* 5A Name of the Medicare contractor that made the redetermination (not required if copy of notice attached)
* 5B Does this appeal involve an overpayment? Yes or No

Block 6 - I do not agree with the redetermination decision on my claim because: Be as specific as possible including the appropriate codes and description of the service, billed amounts, etc. This information is particularly important if you are questioning multiple lines on a claim. Including the internal control number of the claim in question helps ensure the QIC has all the information needed to complete the reconsideration request. A copy of the redetermination letter with your reconsideration request can also help ensure your request is handled in the most efficient manner possible.

Block 7 - Additional information Medicare should consider

Block 8 - Check one of the boxes:

* I have evidence to submit. Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration.
* I do not have evidence to submit.

Block 9 - Person appealing: Check the appropriate block of the person appealing the request

Block 10 - Name, address, email and telephone number of person appealing

Block 11 - Date signed

Key Points / Instruction / What you need to know

Reconsideration is the second level appeal.

It is an independent reexamination of a claim.

Complete this form when you do not agree with the first level of appeal, which is a redetermination.

A request for reconsideration must be filed within 180 days after the date of receipt of the redetermination notice.

Note: This form is not to be used for or with any other request (e.g., account receivable requests, enrollment forms, etc.). Visit the Forms page for complete form listing / instruction.

Where to send the form

|  |  |  |
| --- | --- | --- |
| JH / JL Part A | JH Part B | JL Part B |
| C2C Innovative Solutions, Inc. | C2C Innovative Solutions, Inc. | C2C Innovative Solutions, Inc. |
| QIC Part A East Appeals  P.O. Box 45305  Jacksonville, FL 32232-5305 | QIC Part B South  P.O. Box 45300  Jacksonville, FL 32232-5300 | QIC Part B North  P.O. Box 45208  Jacksonville, FL 32232-5208 |
| Fax: 904-539-4074 | Fax: 904-539-4090 | Fax: 904-539-4081 |
| [Appeal Portal](https://www.c2cinc.com/Appellant-Signup) | [Appeal Portal](https://www.c2cinc.com/Appellant-Signup) | [Appeal Portal](https://www.c2cinc.com/Appellant-Signup) |

Common errors:

Missing information on forms:

* Beneficiary name
* Medicare Beneficiary ID number
* The specific service(s) and / or item(s) for which the reconsideration is being requested
* The specific date(s) of the service
* The name of the requestor
* The name of the contractor that made the redetermination decision