## MEDICARE RECONSIDERATION 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 redetermination notice
	(If you received your redetermination more than 180 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.
15.	Name of the Medicare Contractor that Made the Redetermination:
NO	<b>TICE:</b> Anyone who misrepresents or falsifies essential information requested by this form may upon

conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20033 (05/05) EF (05/2005)