Notice of Dismissal of Appeal Request

Date: _____

Enrollee's Name: _____ Enrollee ID Number: _____

(Insert Non-contract Provider Name, if applicable:) _____

Health Plan Name/Medicare Contract Number: _____

Health Plan Contact Fax Number: _____

- We dismissed the appeal request you filed on _____
  (Insert date request received by the plan.)
- We can't process your appeal request because:
  (Instructions: Use the space below to explain the specific reason for dismissal and what is missing from the request (e.g., lack of an appointment of representation (AOR) form, lack of waiver of liability (WOL) for a request filed by a non-contract provider). See Chapter 13 of the Medicare Managed Care Manual for guidance on when it may be appropriate to dismiss a reconsideration request.)

Do You Have Questions?

If you have questions about this notice, please contact _____at the following:
(Insert Health Plan Name)

Toll Free Phone: _____ Days & hours of operation: _____

TTY Users Phone: _____ Days & hours of operation: _____

If you disagree with our decision to dismiss your appeal request, you have the right to ask an independent reviewer contracted with Medicare to review our decision. You must mail or fax your written request within 60 calendar days of receipt of this ***Notice of Dismissal of Appeal Request*** to:

MAXIMUS Federal Services, Inc.
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302

Phone: 585-348-3300
Fax: 585-425-5292

Include a copy of this ***Notice of Dismissal of Appeal Request*** along with any supporting information with your request for review. The independent reviewer will send you a notice of its decision. If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will be returned to _____ for processing.
(Insert Health Plan Name)