

Notice of Dismissal of Appeal Request

Date:

Enrollee's Name:

Enrollee ID Number:

(Insert non-contract provider name, if applicable):

Health Plan Name:

Phone:

Fax:

We dismissed the appeal request you filed on *(insert date)*.

We can't process your appeal because: *(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 the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for when it may be appropriate to dismiss a reconsideration request.)*

Do You Have Questions?

If you have questions about this notice, please contact *(Insert plan name)* at:

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 *(Insert plan name)* for processing.