

**DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298**

MODEL FORM A – INDIVIDUAL APPEAL REQUEST

Date of Request: _____
Provider Name: _____
Provider Number: _____
Fiscal Year Ended: _____
Intermediary/MAC: _____

1. Date of Notice of Final/Revised Determination: _____

Type of Final Determination: _____ Notice of Program Reimbursement (NPR)
(Check one) _____ Revised NPR
_____ Exception Determination
_____ Federal Register Notice
_____ Failure to Issue a Timely Determination
_____ Other (Specify: _____)

YOU MUST ATTACH A COPY OF THE FINAL/REVISED DETERMINATION UNDER A TAB LABELED 1.

*** If appealing from a Revised NPR, you MUST also provide copies of:** (1) the NPR immediately preceding the Revised NPR under appeal, (2) the Reopening Request that preceded the Revised NPR (if applicable), (3) the Reopening Notice issued by the Intermediary, (4) the Revised NPR workpapers (for the issue(s) under appeal), and (5) any applicable cost report worksheets (e.g., Worksheet E). *See Rule 7.1.*

*** If claiming Intermediary/MAC failed to issue a timely Final Determination, state the date the cost report was sent to the Intermediary:** _____. You **MUST** also include copies of: (1) the certification page of the perfected or amended cost report, (2) the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports, (3) the Intermediary's letter or e-mail acknowledging receipt of the as-filed and any amended cost reports, (4) evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and (5) the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items. *See Rule 7.4.*

*** If receipt of Final/Revised Determination is more than five days after date of determination, state date received:** _____. You **MUST** also include a copy of documentation to support the actual date of receipt.

2. **Does this Request include a request for Expedited Judicial Review?** _____ YES _____ NO
NOTE: A request for EJR must be submitted in a separate document and “EJR Request” must be marked on the outside of the envelope.

3. **Is the Provider requesting Mediation?** _____ YES _____ NO
NOTE: If yes, a request must be submitted in a separate document.

4. Provider Information:

Provider Name: _____
Provider Contact/Title: _____
Provider Address: _____

Provider Telephone Number: _____
Provider Fax Number: _____
E-mail Address: _____

5. **Is this Provider commonly owned or controlled?** _____ YES _____ NO
NOTE: If yes, identify the following contact information for the parent organization:

Corporation Name: _____
Contact Person at Corporation: _____
Corporation Address: _____

Telephone Number: _____
Fax Number: _____
E-mail Address: _____

6. Intermediary/MAC Information:

Intermediary/MAC Name: _____
Intermediary Address: _____

Intermediary/MAC Code (from NPR, if known): _____

7. Representative Information (if applicable):

Representative Name: _____
Company Name: _____
Company Address: _____

Phone Number: _____
Fax Number: _____
E-mail Address: _____

NOTE: If you are filing as a representative, YOU MUST ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. See Rule 5.4.

8. Issue(s) Appealed:

UNDER A **TAB LABELED 3**, YOU MUST SUBMIT A STATEMENT OF THE ISSUE(S). The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board’s Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).

Total Amount in Controversy for all Issues: _____

CERTIFICATIONS

A. I certify that none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

Printed Name: _____

Title: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

B. I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same calendar year covered in this request. *See* 42 C.F.R. § 405.1835 (b)(4)(i).

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

C. I certify that a copy of this Request (and any supporting documentation) was sent by
(Check one)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Intermediary/MAC on this _____ day of _____, 2____.

Certified Mail or Tracking Number: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____