Print Form

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

MODEL FORM A – INDIVIDUAL APPEAL REQUEST

Date of Request: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Intermediary/MAC: _____

Notice of Final Determination Dated: _____
YOU MUST ATTACH THE FINAL DETERMINATION UNDER A **TAB LABELED 1**.

***If claiming intermediary/MAC failed to issue a timely Final Determination, state date cost report was sent to intermediary: _____**
(Include copy of the cost report certification page and any other evidence to support the date the cost report was filed.)

Does this Request for Hearing 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.)

Is the Provider requesting Mediation? (If yes, a request must be submitted in a separate document.)
_____ YES _____ NO

Provider Information:

Provider Name: _____

Provider Contact/Title: _____

Provider Address: _____

_____

_____

Provider Telephone Number: _____

Provider FAX Number: _____

E-mail address: _____

Is this Provider commonly owned or controlled? _____ YES _____ NO

If **YES**, identify the name of the corporation, name of the contact person at the corporation, the address and telephone number: _____

_____

_____

Intermediary/MAC Information:

Intermediary/MAC Name: _____

Address: _____

_____

_____

Intermediary/MAC Code: _____

(From NPR, if known)

Representative Information (if applicable):

Representative's Name: _____

Company Name and Address: _____

_____

_____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

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

Issue(s) Appealed:

UNDER A **TAB LABELED 3** YOU MUST SUBMIT A STATEMENT OF THE ISSUE. The statement of the issue must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and include: (1.) 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 (Cite 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: _____ Date: _____
(Provider Owner/Officer/Director or Representative)