

**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 D – REQUEST TO TRANSFER ISSUE TO A GROUP APPEAL
YOU MUST FILE AN ORIGINAL AND 1 COPY OF THIS FORM (MARKED COPY)**

Date of Request: _____

Prior PRRB Case No(s): _____

(NOTE: You MUST provide full transfer history if issue has presided in more than one case.)

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

- 1. Describe the Issue that is being transferred and include the relevant audit adjustment number, if applicable:**

- 2. Is this the last issue remaining in the individual appeal?** _____ YES _____ NO
If so, check Yes and the individual case will be closed due to the transfer of the remaining issue.

- 3. What is the PRRB Group Case Number and name of the group to which the issue is being transferred?**

Group Case No.: _____

Group Case Name: _____

NOTE: If the group appeal to which you are requesting to transfer has not yet been assigned a case number, please provide the following information OR attach a copy of the group appeal request:

Date of Group Appeal Request: _____

Group Representative's Name: _____

Group Representative's Company: _____

Proposed Name of Group Appeal: _____

NOTE: Transfers using this form can ONLY be made to existing group appeals and to group appeals that have been requested previously, but which have not yet been assigned a case number by the Board. If you attempt to transfer an issue to a group case that has not yet been requested to be established, your transfer request will not be processed and the issue will remain in the individual appeal.

4. **Is this a commonly owned or controlled Provider?** _____ **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: _____

5. **Is the group a mandatory Common Issue Related Party (CIRP) group appeal?** _____ **YES** _____ **NO**

6. **Is the Provider a member of the CIRP?** _____ **YES** _____ **NO**

NOTE: (*See* Rules 12.5 and 12.6.) Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least \$50,000. Providers that are not part of a CIRP group may not join a CIRP appeal. Providers that are part of CIRP organizations may not join an optional group unless the \$50,000 aggregate amount in controversy requirement cannot be met by the CIRP Providers or there are not at least two providers in the CIRP organization that have the issue.

7. **If you are a CIRP provider who is attempting to transfer an issue to a group appeal involving independent hospitals, you must document why this action is appropriate in the space below** (An example of an appropriate response is “The provider certifies that no other commonly owned providers have, nor will have the same issue pending for the same calendar year.”)

8. Please check below the statement which describes when the issue was added to this appeal and attach the required documentation to support that the issue was timely raised consistent with the checked box.

NOTE: *The issue must be included in the individual appeal **before** it can be transferred to a group appeal. See 42 C.F.R. § 405.1835.*

_____ The issue was included in the original appeal request. In order to confirm that this issue was included in the original appeal request, you **MUST ATTACH** a copy of the original appeal request and/or a copy of Model Form A – Individual Appeal Request (including attachment with the statement of issue(s)).

_____ The issue was added to the Provider’s pending appeal. In order to confirm that this issue was added to the pending appeal, you **MUST ATTACH** a copy of the letter requesting to add the issue and/or a copy of Model Form C – Request to Add Issues Request (including attachment with the statement of issue(s)).

9. Are you the representative for the individual appeal from which the issue is being transferred? _____ YES _____ NO

NOTE: *If you answered “NO”, the Provider/Representative **MUST SIGN** Section A of the Certification Page and you will be required to submit an authorization of representation signed by an official of the Provider when you submit the final Schedule of Providers with the associated jurisdictional documentation.*

CERTIFICATIONS

- A. I certify that this issue is not pending in any other appeal for the same period, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal. The Provider has been notified that this issue is being transferred to the group appeal case number _____. The Provider agrees with this transfer.

Printed Name: _____

Title: _____

Signature: _____
(Provider/Representative Transferring Issue)

Date: _____

- B. I have reviewed the regulations at 42 C.F.R. § 405.1837, the Board Rules and consulted with the Provider/other representative identified on this form. I have a good faith belief that this transfer request meets the single common issue requirement for a group appeal.

Printed Name: _____

Title: _____

Signature: _____
(Group 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 Lead Intermediary/MAC for the group (if known) and the local Intermediary for the Provider (if different) on this _____ day of _____, 2____.

Certified Mail or Tracking Number(s): _____

Signature: _____
(Group Representative)

Date: _____