DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM C – REQUEST TO ADD ISSUE(S) TO AN INDIVIDUAL APPEAL

Date of Request: _____

Individual PRRB Case No.: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Date of Original Hearing Request: _____

A provider may add issues to an appeal provided the request conforms to the requirements of 42 C.F.R. § 405.1835(c).

1. **Issue(s) Being Added to Case:**

   _____

   _____

   UNDER A **TAB LABELED 1** YOU MUST SUBMIT A STATEMENT FOR EACH ISSUE BEING ADDED TO THIS APPEAL. 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 information to demonstrate provider preserved its right to appeal; (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (Cite statutes, regulations and/or manual provisions).

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. **Is this issue being transferred concurrently to a group appeal?** ☐ **YES** ☐ **NO**
   NOTE: If yes, you must attach **Model Form D.**

5. **Representative Information:**
   Are you the representative on file for this individual appeal? ☐ **YES** ☐ **NO**
   NOTE: If you are not the representative on file or who established this appeal, then you must attach an authorization letter signed by an official of the provider.

CERTIFICATIONS

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added to this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.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