

**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 E – REQUEST TO JOIN AN EXISTING GROUP APPEAL:
DIRECT APPEAL FROM FINAL DETERMINATION**

Date of Request: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Intermediary/MAC: _____

1. 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.

2. 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 LABELLED 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.

NOTE: Joinder to an existing group must meet the timeliness requirements of 42 C.F.R. § 405.1837(g).

3. Description of Issue (include the relevant audit adjustment number, if applicable):

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

7. **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.

8. **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.”)

9. **Representative Information (if applicable):**

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.

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 added to the group appeal case number _____. The Provider agrees with request.

Printed Name: _____

Title: _____

Signature: _____
(Provider/Representative Adding Issue)

Date: _____

- B. I have reviewed the regulations at 42 C.F.R. § 405.1837, and the Board Rules and consulted with the Provider/other representative identified on this form. I have a good faith belief that this addition 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: _____