National Government Services

A CMS Medicare Administrative Contractor

MEDICARE

Home Health Third Party Liability Demand Bill Redetermination Request Form

1. Beneficiary's Name: ______________________________
2. Beneficiary's Medicare (Health Insurance Claim) Number: ______________________________
3. Date(s) of Service: ______________________________
4. I do not agree with the determination of my claim. My reasons are: ______________________________

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5. Date of the initial determination notice: ______________________________

   Note: If you received your initial determination notice more than 120 days ago, please include your reason for not making this request earlier. ______________________________

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6. Additional information Medicare should consider: ______________________________

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7. Requester's Name: ______________________________
8. Requester's Address: ______________________________
9. Requester's Telephone Number: ______________________________
10. Requester's Signature: ______________________________
11. Date Signed: ______________________________

The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your claim. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed to the Centers for Medicare and Medicaid Services or another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES