

## Notice of Dismissal of Appeal Request

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**Date:**

**Enrollee Name:**

**Enrollee ID Number:**

***(Insert non-contract provider name, if applicable):***

Health Plan Name:

Phone:

Fax:

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We dismissed the appeal request you filed on *(insert date)*.

We can't process your appeal because: *(explain the specific reason for dismissal and what is missing from the request -- e.g., person making the request is not a proper party and there isn't an appointment of representation (AOR) form; lack of waiver of liability (WOL) for a request filed by a non-contract provider; untimely filing of appeal and there isn't good cause for the late filing; a party submits a timely request for withdrawal of the reconsideration request. 42 CFR §§ 422.582(f) and (g), 422.633(h) and (i); for additional guidance, see also the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for when it may be appropriate to dismiss a reconsideration request.)*

### What to do next

**If you disagree with our decision to dismiss your appeal request,** you have two options:

- 1. You have the right to ask us to vacate (set aside) the dismissal action.** If we determine there's good cause to vacate the dismissal because *<insert reason for finding good cause--e.g., a finding that the person who made the request is a proper party>*, we'll vacate our dismissal and review your coverage request again. We must get your request at *<insert address/fax/phone>* within **6 months** of the date on this notice. Include a copy of this notice and any supporting information with your request.
- 2. You have the right to ask an independent reviewer contracted with Medicare to review our decision.**

If you want an independent reviewer to review our decision, you must send your request within **65 calendar days** of the date of this notice. **Include a copy of this Notice of Dismissal of Appeal Request** along with any supporting information you want the independent reviewer to consider. The independent reviewer will send you a notice of its decision.

Submit your written request by mail or fax to:

MAXIMUS Federal Services, Inc.  
Medicare Managed Care & PACE Reconsideration Project  
3750 Monroe Avenue, Suite 702  
Pittsford, NY 14534-1302  
Fax: 585-425-5292  
Phone: 585-348-3300

If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will go back to *<Insert plan name>* for processing.

## **Get help and more information**

**For questions** about this notice, contact (*Insert plan name*) at toll-free at (*insert Toll Free Phone*) on (*days & hours of operation*). TTY users can call (TTY phone).