MEDICARE REDETERMINATION REQUEST FORM

Please send the completed form and any additional information to eternalHealth.

- **By Fax:** 888-692-7270
- **By Mail:** P.O. Box 1377, Westborough, MA 01581
- **By Phone:** 800-680-4568

Member Information	
Member Name (Last, First, MI)	
Product Name	
Member ID #	
Member Date of Birth (MM/DD/YYYY)	
Member Phone (include area code)	

Redetermination Information	
Product or Service	
Date the Product or Service Was Received (MM/DD/YYYY)	
Date of the Initial Determination (MM/DD/YYYY)	Please include a copy of the initial determination letter with this request.
If you received your initial determination letter more than 60 days ago, please include your reason for filing this request late.	
I do not agree with the initial determination decision because:	
Additional information that should be considered:	

eternalHealth

MEDICARE REDETERMINATION REQUEST FORM

I have additional evidence to submit.	☐ Yes ☐ No Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.
For providers and suppliers only	
Does this Appeal Involve an Overpayment?	☐ Yes ☐ No

Person Appealing Information			
Relationship of Person Appealing	☐ Member ☐ Provider/Supplier ☐ Authorized Representative		
Name of Person Appealing (Last, First, MI)			
Street Address			
City		**State**	**Zip Code**
Phone Number (include area code)	**Date of Appeal** (MM/DD/YYYY)		
Signature (By typing your name here, you attest that the information given is true and accurate to the best of your knowledge)			

Privacy Act Statement: 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 appeal. 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 appeal. Information you furnish on this form may be disclosed by the Centers for Medicare & Medicaid Services to 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. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html