The reconsideration request should be sent to:

Palmetto GBA
Part B Provider Enrollment (AG-310)
P.O. Box 100190
Columbia, SC 29202-0190

Or emailed to:

JMAppealRequest@PalmettoGBA.com

For questions concerning this letter, contact our Provider Contact Center at (855) 696-0705 between the hours of 8:00 AM and 4:30PM.

Sincerely,

Provider Enrollment Analyst

Appeal Information Cover Sheet

PLEASE INCLUDE THIS COMPLETED FORM WITH YOUR APPEAL.

Improperly submitted requests may be dismissed

Provider/Supplier Name: ______________________

Provider/Supplier Mailing Address: ______________________

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National Provider Identifier (NPI): ______________________

Medicare ID Number (PTAN): ______________________

Provider/Supplier Email Address: ______________________

Provider/Supplier Fax Number: ______________________

Medicare Administrative Contractor: Palmetto GBA JM

This appeal submission is based on a(n): ☐ **Denial** ☐ **Revocation** ☐ **Effective Date** ☐ **Opt-Out**

Are you submitting both a Corrective Action Plan (CAP), Reconsideration Request, or both? CHOOSE ALL THAT APPLY:

☐ **Corrective Action Plan (CAP)** – *The CAP is an opportunity for the provider/supplier to correct the deficiencies (if possible) that resulted in the denial or revocation.* ***A CAP may only be submitted for denials under 42 C.F.R. § 424.530(a)(1) or revocations under 42 C.F.R. § 424.535(a)(1).***

Your CAP submission must:

1. Contain verifiable evidence that the provider/supplier is in compliance with Medicare requirements;
2. Be submitted within 35 days from the date of the denial or revocation notice;
3. Be submitted in the form of a letter that is properly signed and dated.

A decision will be issued within 60 days of receipt of the CAP.

The time to submit a reconsideration request runs concurrently with the time to submit a CAP. For example, if a CAP is submitted 20 days after the initial determination, there are 45 days remaining to submit a reconsideration request. These 45 days continue to elapse while the CAP is under consideration. Please note that failure to timely request a reconsideration is deemed a waiver of all rights to further administrative review.

☐ **Reconsideration Request –** *A reconsideration request is an opportunity for a provider/supplier to furnish evidence that demonstrates that there was an error made at the time of the initial determination affecting participation in the Medicare Program.*

Your reconsideration request must:

1. State the issues, or the findings of fact with which you disagree, and the reasons for disagreement.
2. Be submitted within 65 days from the date of the initial determination;
3. Be submitted in the form of a letter that is properly signed and dated.

A decision will be issued within 90 days of receipt of the reconsideration request.