

## Notice of Dismissal of Appeal Request

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**Date:**

**Enrollee's 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.)*

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### Do You Have Questions?

**If you have questions** about this notice, please contact *<Insert plan name>* at:

Toll Free Phone:

Days & hours of operation:

TTY Users Phone:

Days & hours of operation:

**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 is 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 will vacate the dismissal and review your appeal request. Your request to vacate this dismissal must be received by our office at *<insert address/fax/phone>* within **6 months** of the date of this notice. Include a copy of this *Notice of Dismissal of Appeal Request* along with any supporting information with your request.
2. **You also have the right to ask an independent reviewer contracted with Medicare to review our decision to dismiss your appeal request.** If you want an independent reviewer to review our decision,

you must mail or fax your written request within **60 calendar days** of the date of this *Notice of Dismissal of Appeal Request* to:

MAXIMUS Federal Services, Inc.  
Medicare Managed Care & PACE Reconsideration Project  
3750 Monroe Avenue, Suite 702  
Pittsford, NY 14534-1302

Phone: 585-348-3300  
Fax: 585-425-5292

Include a copy of this *Notice of Dismissal of Appeal Request* along with any supporting information with your request for review. The independent reviewer will send you a notice of its decision. If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will be returned to <Insert plan name> for processing.