



WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Puerto Rico

Form revised 10/1/2019

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, and 11 but to help us serve you better; please include a copy of the redetermination notice with your request.

Submit requests to: C2C Innovative Solutions Inc.
QIC Part B South
P.O. Box 45300
Jacksonville, FL 32232-5300

1. Name of Beneficiary: _____

2a. Medicare ID: _____

2b. Claim Number (ICN/DCN if available): _____

3. Provider Name: _____

4. Person Appealing: Beneficiary Provider of Service Representative

5. Address of the Person Appealing: Address _____
City _____ State _____ ZIP Code _____

5a. Telephone Number of the Person Appealing: _____

5b. Email Address of the Person Appealing: _____

6. Item or service you wish to appeal: _____

7. Date of the service: From _____ To _____

8. Does this appeal involve an overpayment? Yes No

Please include a copy of the demand letter with your request.

medicare.fcso.com



First Coast Service Options Inc.

9. Why do you disagree? Or what are your reasons for appeal? (255 character limit; attach additional pages if necessary.)

10. You may also include any supporting materials to assist your appeal. Examples of supporting materials include:

Medical Records

Office Records/Progress Notes

Copy of the Claim

Treatment Plan

Certification of Medical Necessity

11. Printed Name of Person Appealing:

Contractor Number 09202	Redetermination Number
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