**Notice of Dismissal of Appeal Request**

**Date:**

**Enrollee’s Name: Enrollee ID Number:**

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

Health Plan Name: Phone: Fax:

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.)*

**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. Phone: 585-348-3300

Medicare Managed Care & PACE Reconsideration Project Fax: 585-425-5292

3750 Monroe Avenue, Suite 702

Pittsford, NY 14534-1302

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.