

## Notice of Dismissal of Appeal Request

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**Date:**

**Enrollee's Name:**

**Enrollee ID Number:**

**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; untimely filing of appeal and there isn't good cause for the late filing; a party submits a timely request for withdrawal of the redetermination request. See: 42 CFR § 423.582(e) and (f) and the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for when it may be appropriate to dismiss a redetermination 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 at 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, fax or transmit your written request within **60 calendar days** of the date of this *Notice of Dismissal of Appeal Request* to:

United States Postal Service (USPS):  
C2C Innovative Solutions, Inc.  
Part D Drug Reconsiderations  
P.O. Box 44166  
Jacksonville, FL 32231- 4166

UPS / FedEx ONLY:  
C2C Innovative Solutions, Inc.  
Part D Drug Reconsiderations  
301 W. Bay St., Suite 1110  
Jacksonville, FL 32202

**Toll Free Fax: (833) 710-0580**

**Web Portal Address: <https://www.c2cinc.com//Appellant-Signup>**

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.