

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Instructions for Medicare Redetermination Request Form

Line 1: Fill in the enrollee's full name.

Line 2: Fill in the enrollee's AlohaCare Advantage or Advantage Plus Member number.

Line 3: State the item, drug, or service in question.

Line 4: Write the date the item, drug, or service was received.

Line 5: On the next few lines or on a separate piece of paper you attach to this form write why you do not agree with AlohaCare's decision.

Line 6: Write the initial date of determination notice. (This will be found on the AlohaCare Advantage or Advantage Plus letter denying the service.) If it has been longer than 4 months include the reason for not asking for redetermination earlier.

Line 7: Is there any other information concerning this situation you feel Medicare should know? Write this information in the space provided or on another sheet of paper you attach to this form,

Lines 8, 9, 10, & 11: If someone other than the enrollee is filing out this form or requesting this they will need to fill in the Requestor information with their name, address, phone number, and relationship to the enrollee. They will also need to complete the CMS form Appointment of Representative (CMS 1696), have it notarized, and send it in with this form.

Lines 12 & 13: Enrollee or Requestor signature and the date this form was completed.

Line 14: If you have any separate documentation to submit (including extra pages for lines 5, 6, & 7 or form CMS 1696 Appointment of Representative) check the first box. If you have nothing extra to submit check the last box.

You may mail the form or fax it to: AlohaCare Advantage –Customer Service
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Fax: (808) 973-0726

If you have any questions, please call our AlohaCare Advantage Customer Service Department at 973-6395 on Oahu or toll free at 1-866-973-6395 from the Neighbor Islands or the Mainland. TTY users should call 1-877-447-5990 toll free. We are open Monday through Friday from 8:00 am to 5:00 pm.