APPENDIX A

Appendix A: Reconsideration Case Forms and Instructions

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APPENDIX A

INSTRUCTIONS FOR RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

PACE ORGANIZATION RECONSIDERATION PROJECT

Instructions for Completion of :
PACE Organization Reconsideration Background Data Form and Case Narrative

1.0 GENERAL ORGANIZATION OF SUBMITTED NEW CASE FILE MATERIAL

Consult the appropriate *MAXIMUS CHDR PACE Organization Reconsideration Process Manual* for general instructions on Reconsideration case file development. The instructions that follow apply to completion of the mandatory:

- Reconsideration Background Data Form
- Case Narrative

2.0 INSTRUCTIONS FOR COMPLETION OF RECONSIDERATION BACKGROUND DATA FORM

The PO must submit a completed Reconsideration Background Data Form with each new IRE Reconsideration case file. The form provides MAXIMUS CHDR with information necessary for case administration and processing. In addition, MAXIMUS CHDR directly reports to CMS certain data entered on the form by the PO. MAXIMUS CHDR will report this data as given by the PO on the *Reconsideration Background Data Form* and will not attempt to correct errors or omissions.[1]

Electronic versions of the form are located on the Medicare Managed Care Reconsideration Web site, maintained by MAXIMUS CHDR at www.medicareappeal.com.

POs may develop their own "local" version of the Reconsideration Background Data Form, for example to modify spacing or accommodate electronic completion. Prior to implementation, the PO should submit any proposed local version to MAXMUS CHDR for review.

We recommend that the PO type all entries to the *Reconsideration Background Data Form.* If not, the person completing the form should write legibly and print if necessary.

[1] For certain compliance data elements (e.g. dates for PO appeal activity), MAXIMUS CHDR reports to CMS both the dates provided by the PO on the Reconsideration Background Data Form and, separately, any discrepancy noted by MAXIMUS CHDR based upon other case file material. For example, MAXIMUS CHDR would report a discrepancy to CMS if the date on a notice document did not correspond to the date entered for that notice on the Background Data Form.

The required format for all "date" entries is MM/DD/YY.

All sections of *the Reconsideration Background Data Form* are mandatory, as is each applicable element within a section, per the instructions below. Do not leave a mandatory section or data element blank if you are uncertain how to code it. Contact MAXIMUS CHDR prior to completing the form.

The form completion instructions, per Section and data element, are as follows.

I. CASE CLASS

Put an X in front of the appropriate case class. Note that some cases have 2 or more class components (e.g., both a standard service and standard claim component). Mark each case class that applies. MAXIMUS CHDR will process the case at the "highest" class assigned by the PO.

II. ENROLLEE AND REPRESENTATIVE DATA

Enrollee Name, Medicare Number and Telephone Number

Format name as Last, First, Middle. The Medicare or Medicaid number ("HIC number") is critical to MAXIMUS CHDR administration. MAXIMUS CHDR is unable to initiate the case without the correct HIC number and therefore, will not recognize receipt of the case until the PO provides the correct HIC number.

Provide enrollee telephone number, including area code, if available.

Enrollee Address

Provide the last known address even if the enrollee is deceased. Indicate whether the enrollee is living or deceased.

The enrollee information is required even if the reconsideration is submitted by an authorized representative.

Representative

Another person may represent an enrollee. The PACE Organization is responsible to verify that the representative is the appropriate designated represented for the enrollee. Provide the representative's address, to enable MAXIMUS CHDR to send correspondence to that individual.

Translation Request

MAXIMUS CHDR will provide determination letters in languages other than English. If the enrollee requires the MAXIMUS CHDR Reconsideration Determination Notice in a language other than English, please notify MAXIMUS CHDR through the Reconsideration Background Data Form. The language in which the document must be translated must be included in the form.

III. PACE ORGANIZATION DATA

PO Name and Identifying Data

Enter the name of the Po and the CMS Contract Number. Enter the exact address to which MAXIMUS CHDR should send correspondence for this particular case (i.e., the Case Contact address). This may, or may not, be the address used by the PO to correspond with CMS for other purposes.

Contact Person For This Reconsideration

The PO may designate any authorized individual to act as the liaison with MAXIMUS CHDR for the submitted case. The PO may use different authorized individuals for different cases.

Enter the name, title and contact information for the person acting as the point of contact for this particular case.

IV. PACE ORGANIZATION PROCESSING DATES

IV(A). Organization Determination

Date of Request for Organization Determination

The PO should determine the "date of Organization Determination request" on the basis of the history and facts of the case.

Enter the date in MM/DD/YY format.

Did the PO take a 5-day Extension?

CMS regulations (42 CFR §460.104(c)(iii)) permit the PO to take up to a 5-day extension in making the organization determination if the extension is taken "in the enrollee's interest."

Check "yes" if the PO purposefully took such an extension. Do not check "yes" if the PO was late in case processing for reasons other than an extension in the enrollee's interest. If the PO checks "yes" MAXIMUS CHDR will add 5 days in its calculation of PO timeliness.

Check "no" if the PO did not purposefully take an extension.

Date of Organization Determination

Enter the date the Organization Determination was issued using the MM/DD/YY format.

VI(B). PO Reconsideration Determination

Date of Request for PO Reconsideration

The PO should determine the "date of PO Reconsideration request" on the basis of the history and facts of the case.

Enter the date in MM/DD/YY format.

Did Enrollee Or Provider Make and Expedited Request for an Expedited PO Reconsideration?

Check "yes" or "no."

Was the Expedited Request Granted.?

Check "yes" if the PO expedited the case, *whether or not* the enrollee asked for the case to be expedited. "Yes" must be checked if the PO indicated the case class is "Expedited." If "yes" is checked and/*or* the case class is expedited, MAXIMUS CHDR will apply the timeframes for expedited case processing in reporting compliance to CMS.

Check "no" if a request for expedited determination was not granted.

Did the PO take a 14-day Extension?

CMS regulation (42 CFR §460.124) permit the PO to take up to a 14-day extension in making the expedited Reconsideration Determination if the extension is taken "in the enrollee's interest."

Check "yes" if the PO purposefully took such an extension. Do not check "yes" if the PO was late in case processing for reasons other than an extension in the enrollee's interest. If the PO checks "yes" MAXIMUS CHDR will add 14 days in its calculation of PO timeliness.

Check "no" if the PO did not purposefully take an extension.

Date of PO Reconsideration Determination

Enter the date the PO Reconsideration Determination was issued using the MM/DD/YY format.

IV(C). Request for IRE Review

Date of Request for IRE Review

The PO should provide the on which the enrolle requested IRE review of the appeal based on the history and facts of the case.

Enter the date in MM/DD/YY format.

Did Enrollee Or Provider Make and Expedited Request for an Expedited IRE Review?

Check "yes" or "no."

Date PO Case File sent for IRE Review

The PO should provide the date in which the PO reconsideration case file was prepared and sent to the IRE for an independent review of the appeal.

Enter the date in MM/DD/YY format.

V. DESCRIPTION OF ITEM OR SERVICE IN DISPUTE

V (A). Definition of Denied Items

Description of Item or Service in Dispute

The purpose of this section is to provide MAXIMUS CHDR with a succinct definition of the one, or more, denied claims or services addressed in the case file.

A separate line should be completed for each discrete, or different, service that is contested in the Reconsideration. A service is "different" if it is sought from or rendered by a different provider, or consists of a different type of care, unrelated procedure, or item. It is not necessary to use a separate line to define multiple occurrences of the same service (e.g., different dates of physical therapy or days within an inpatient stay).

The brief description of denied item should be a succinct definition of the service or item, which is contested. You need only define the denied item itself (e.g., "motorized wheel chair"). Do not attempt to provide background or explain arguments of the PO or the enrollee.

Estimated Dollar Amount in Dispute

Enter the dollar amount in dispute. If the actual dollar amount is unknown, please provide a best estimate.

Dates of Service

For disputes regarding services not yet provided, leave blank. For disputes regarding payment for services already received, list date(s) on which the service was provided.

V(B). Provider Identification

The purpose of this section is to assist MAXIMUS CHDR in identifying *each* provider that is referenced in the PO's case file. POs should include the provider(s) of denied, or unauthorized, services, as well as any other provider who plays a significant role in the sequence of events surrounding the denial of services or payment. POs need not identify providers who are merely a part of the member's general utilization history (i.e., history unrelated to the denied services).

Each provider is recorded in this section *only once.* If there are more than 5 providers, expand the table or attach a second sheet.

Complete the "Type", "Specialty", "Relationship to PO", and "Medical Records" fields using the codes provided on the form for each of these fields. Indicate whether the provider is located in or out of the service area of the PO by use of a Yes or No in the "In Area" field.

The purpose of the Medical Records field is for MAXIMUS CHDR to easily determine if records are found in the case file and, if not, whether the PO has attempted to obtain charts. If issues exist regarding sufficiency or availability of medical records, these issues should be discussed in the case narrative.

VI. ATTESTATION

The attestation is now required as a means of PO certification that the information provided on the PACE Organization Reconsideration Background Data Form and included within the case file is complete and accurate, to the best of the POs knowledge.

Completion of the Attestation is mandatory.

3.0 CASE NARRATIVE

The outline for the required Case Narrative is contained on page 4 of the Reconsideration Background Data Form for reference only. The PO should supply Case Narrative as a document separate from (not attached to) the Reconsideration Background Data Form. The Case Narrative must be typed.

The mandatory sections of the Case Narrative are:

- Case Summary
- Chronology of Care
- Enrollee's (or other party's) Arguments for Coverage
- PO Reason for Denial

I. CASE SUMMARY

Briefly describe the relevant medical history and current condition, including significant changes in status, of the enrollee. Explain how the enrollee came to request the service(s) that the PO denied.

Provide an exact description of the item(s) requested by the enrollee and denied by the PO that are contested in the appeal. Include any relevant technical definition of the denied item that facilitates research regarding CMS coverage policies. If the PO has offered to provide alternative or partial care, and this is important to understanding the context of the denial, explain.

The purpose of the summary is to orient the MAXIMUS CHDR reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph or two.

II. CHRONOLOGY OF CARE

Define those events that are relevant to an understanding of the enrollee's needs or demands, and how the PO has attempted to respond. Emphasize meaningful communication, not length. It is not necessary that the Chronology repeat appeal processing dates, which are provided on the Reconsideration Background Data form.

The Chronology should be presented in a Date/Event format:

DATE	EVENT

Examples of events that a well-written Chronology might contain are:

- Onset of enrollee's illness or condition (as related to the appeal).
- Episodes of care, or care seeking behavior, prior to but related to the appeal itself
- Consultations by which the enrollee becomes aware of, or requests, the denied service
- How the PO responded to the enrollee's request

- Episodes of care, or care seeking behavior, of the enrollee related to the appeal, but subsequent to the PO denial or reconsideration

III. ENROLLEE'S ARGUMENTS FOR COVERAGE

MAXIMUS CHDR assumes the PO has provided the enrollee, (or non contract provider if such provider is the party), with an opportunity to provide input in person, in writing or by phone. In addition, the enrollee may have a formal representative, or may have obtained letters or other evidence of support from plan, or non-plan, providers. "Provider support" is deemed to include a provider's prior authorization request, unless there is clear documentation that the provider who filed the request did not support it.[2]

The PO must provide a faithful summary of each argument advanced by the enrollee and, separately, each argument advanced by a representative or other person supporting the appellant's case. Reference and attach each document in which such an argument is advanced.

Note that if MAXIMUS CHDR identifies a valid argument made by an enrollee or supporting person, and that argument is not acknowledged by the PO, MAXIMUS CHDR may overturn the PO denial without seeking clarification (i.e., without a Request for Additional Information).

IV. PO RATIONALE FOR SERVICE OR CLAIM DENIAL

IV(A). SUMMARY STATEMENT OF REASON FOR DENIAL

Provide a one or two sentence statement of the PO's primary reason(s) for denial. Do not list every conceivable reason for the denial (e.g., "not covered", "not emergent" "not urgent" "not medically necessary" and "not authorized"). List only those reasons applicable to the current case. MAXIMUS CHDR has found that the following terminology for denial reasons is useful for POs. However, POs may indicate their reasons for denial in any terms the PO chooses.

Not Enrolled The PO's records indicate the member was not enrolled on the date(s) that would obligate to PO to cover the disputed service

Not a Covered Benefit The service or item in question is not covered under the member's contract under any normal circumstances (e.g. acupuncture).

[2] A provider might submit a prior authorization request to satisfy the demand of an enrollee, but without that provider's endorsement. The PO would have to provide actual documentation of the provider's lack of endorsement (e.g. a letter from that provider). A general statement, "the provider did not support the request" is not sufficient.

Exceeded Coverage The service is a covered benefit, but the enrollee has exceeded limits set in the subscriber agreement (e.g., covered days, visits or a dollar cap).

Not Justified by PO Delay or Withholding of Care. The service was obtained by the enrollee without authorization or out of network on the argument that the PO delayed or withheld medically necessary care. The PO disputes this argument.

Not The Treatment Option (Or Provider) Approved by PO. Applies to a case in which the enrollee seeks (pre service) or sought (claim denial) a form of treatment that the PO might recognize as medically appropriate, but the PO seeks to limit coverage to an alternative appropriate treatment (or provider).

Not Skilled Care The basis for denial when care is deemed custodial, or fails to meet other Medicare qualifying criteria.

Not Authorized Care not approved in compliance with the PO's authorization procedures. Usually, this reason is secondary or complementary to a reason above (e.g. "the visit to the Emergency Department was not emergent and was not authorized").

Not Medically Necessary A service which is covered by the PO, but which the PO determines fails to meet the definition of reasonable and necessary (42 CFR §411.15).

Not An PO Provider The service sought or obtained by the member was or will be rendered by a provider who is not under contract with the PO or who is not a provider within a defined network available to that member.

IV(B). JUSTIFICATION

The contents of the PO's justification will vary based upon its primary reason for denial. However, it is important the PO justification not only state the PO's position, but also offer a specific rebuttal to each argument advanced by the enrollee, representative, or supporting provider.

Denials On Issues of Coverage

If the PO denies on the basis of coverage, the PO must justify its denial by review and interpretation of the applicable Medicare regulations, guidelines, policies or PO subscriber agreement. The PO must include a copy of the applicable Medicare regulation, guideline policy or provide the exact citation. The citation must be made directly to the applicable federal policy text (e.g., 42 CFR §XXXXX). Do not make citations to secondary sources (e.g., CCH, St. Anthony's Medicare Guide, etc.).

If the PO cites its evidence of coverage, it must provide a complete copy of that subscriber agreement.

Disputes On Matters of Fact

In some cases, the appealing party and PO may disagree on matters of fact (e.g., whether or not the member called for prior authorization on a given date). If the appellant has raised a factual dispute, the PO must directly address the issue raised by the appellant, and provide any (contrary) evidence that may be available.

Denial of Medical Necessity

If the organization determination is based upon a medical judgment (e.g. not emergent, not urgent, not skilled level, not medically necessary), the PO is should obtain the opinion of a physician with appropriate expertise.

The written decisions of these physicians are the most critical components of the POs justification, although a nurse or other staff of the PO may attempt to further document or explain the determinations in the case file. If there is any conflict or difference between the written opinion of the physician's determination vs. other arguments made in the case file, MAXIMUS CHDR may defer to the physician's determination.

The PO may use a format of its choice for documenting the denial of medical necessity. However, the topics the clinical determinations should address are:

- Clinical Summary

  A statement of the relevant medical history and condition of the enrollee, including any status changes that relate to the appropriateness of the denied treatment or care.

- PO Medical Criteria

  Identification and description (copy) of any criteria used by the PO physicians in their adverse determinations. This could include purchased proprietary criteria, PO developed criteria, practice guidelines, recognized medical literature and technology assessments.

  The PO should determine if there are applicable national Medicare coverage guidelines, or Local Medical Review Policies (LMRPs). These should also be included.

- PO Authorized or Recommended Care

  An explanation of care or treatment offered or provided by the PO, if any, in lieu of the (denied) care sought by the enrollee. *The PO must indicate whether this care has actually been offered and authorized, and whether it has been accepted or rejected by the enrollee.*[3]

[3] In most instances, it is not sufficient for the PO to indicate that it is "willing" to provide alternative care. The PO should document that such care has been explained and offered to the enrollee and the enrollee's response.

- Justification for Denial

  If the PO has cited and provided Medicare or PO medical guidelines, the PO should confirm with reference to pertinent medical evidence (records) that the patient meets, or fails to meet, all criteria within those guidelines. If there is an argument that the patient has unique needs and should be exempt from the guidelines, that argument should be addressed.

  If the PO cannot obtain the pertinent medical evidence (records), the PO should document its attempts to obtain the material. In addition, the PO should explain the basis for its uphold in the absence of the medical records. Note that in general, a PO should not automatically deny an enrollee's Reconsideration request solely due to the lack of medical documentation to substantiate medical necessity. See *MAXIMUS CHDR PACE Organization Reconsideration Manual* Section 4.6.

  If the PO determination is based solely on its reviewing physician(s) clinical opinion, that opinion should be explained with reference to the pertinent medical evidence (records).

  If the denied care has been recommended or supported by a medical professional, it is particularly important that the "justification" include a rebuttal to such recommendation.

APPENDIX A
RECONSIDERATION BACKGROUND DATA FORM

PACE ORGANIZATION RECONSIDERATION BACKGROUND DATA FORM

I. CASE CLASS:

- □ Expedited
- □ Standard Service (Pre-authorization)
- □ Standard Claim (Reimbursement**)**

II. IDENTIFYING DATA—ENROLLEE

Enrollee Name:_____ Medicare (HIC)#: _____

Mailing Address: Telephone #:_____

_____

_____ ZIP:_____
City State

Is Enrollee Deceased? □ Yes □ No

Does the Enrollee require the final decision in a language other than English? □ Yes □ No

If Yes, please indicate required language: _____

Designated Representative Information (Complete if Enrollee has a Designated Representative for Reconsideration)

Name:_____ Telephone #:_____

Mailing Address:

_____

_____ ZIP:_____
City State

III. PACE ORGANIZATION INFORMATION

PO Name:_____ CMS Contract #:_____

Mailing Address_____ Plan Type: PACE Organization

City:_____State:_____Zip:_____

Plan Contact:_____

Phone:_____ FAX:_____

Best time to contact (Eastern Time):_____ Email:_____
OPTIONAL

IV. PACE ORGANIZATION RECONSIDERATION CASE PROCESSING DATA

IV(A). Organization Determination

1) Date Request for Organization Determination made: _____ (MM/DD/YY)
2) Did the PO take the up to a 5-day extension? □ Yes □ No
3) Date Organization Determination made: _____ (MM/DD/YY)

IV(B). PO Reconsideration Decision

1) Date Request for PO Reconsideration made: _____ (MM/DD/YY)
2) Was the request for an Expedited PO Reconsideration? □ Yes □ No
2) If request was for an expedited decision, did the PO take the up to a 14-day extension? □ Yes □ No
3) Date PO Reconsideration Decision made: _____ (MM/DD/YY)

IV(C). Request for IRE Review

1) Date Request for IRE Review made: _____ (MM/DD/YY)
2) Was the request for an Expedited IRE Reconsideration? □ Yes □ No
3) Date PO Case File prepared and sent: _____ (MM/DD/YY)

V. DESCRIPTION OF ITEM OR SERVICE IN DISPUTE

V(A). Definition of Denied Items

Item No.	Description of Item of Service in Dispute	Esimated $ Amount in Dispute	Denied Dates of Service
1			
2			
3			

V(B) Provider Identification *(Complete a line for each provider described in case. Do not limit to denied service if a provider is referenced for other purposes, such as role in referral or claim denial process)*

Provider	Specialty	Type	Relation to PO	Medical Records
1				
2				
3				

Codes:

Type

1. Hospital
2. SNF
3. Other facility
4. Freestanding clinic
5. Home health agency
6. Practitioner/professional

Relation to PO

A. PCP/enrollee's primary care center
B. Other PO provider, in network
C. Non plan provider, but under referral from PO
D. No relationship to PO

Medical Records

1. Included
2. Not applicable
3. Not requested
4. Requested/refused

VI. ATTESTATION *I certify on behalf of the PACE Organization defined in Section III, above, that the information on this form and submitted with this case is to the best of the organization's knowledge the true, accurate and complete record of the appeal available to the organization at this time.*

Signed:_____ Print Name:_____

Date:_____

APPOINTMENT OF REPRESENTATION FORM

PACE ORGANIZATION RECONSIDERATION PROJECT

APPOINTMENT OF REPRESENTATIVE STATEMENT

_____ _____
Enrollee Name Medicare/HIC Number

_____ _____
Provider Dates of Service

_____
PACE Organization

I hereby swear that I am the above-mentioned enrollee or have the legal authority to appoint a representative for the above-mentioned enrollee. I appoint the following individual _____ to act as my representative in requesting a reconsideration from the above-referenced PACE Organization and/or MAXIMUS CHDR, as designated external appeal agent of the Centers for Medicare & Medicaid Services.

_____ _____
Signature *Date*

I, _____ hereby accept the above appointment.
(Appointed Representative)

_____ _____
Signature of Appointed Representative Date

APPENDIX A

NOTICE OF INTENT TO SUBMIT AN EXPEDITED RECONSIDERATION FORM

PACE ORGANIZATION RECONSIDERATION PROJECT

NOTICE OF INTENT TO SUBMIT EXPEDITED RECONSIDERATION

This document provides notice of the Medicare managed care plan's intent to submit an Expedited Reconsideration via an overnight delivery service. Please indicate below the date MAXIMUS CHDR should expect delivery and please indicate the overnight delivery vendor. Please only fax this form. Please do not identify the Member via name – use only initials. Please do not send the Expedited case file via fax. MAXIMUS CHDR will not accept any Expedited case files sent via fax.

Enrollee Initials: First_____ Middle: _____ Last:_____

Enrollee HIC Number: _____ - _____ - _____

PO Internal Case Number: _____

PO Name: _____

PO Contact: _____

Contact Telephone Number: _____ Ext.: _____

Contact Email Address: _____

Overnight Delivery Vendor:_____

Date submitted to Overnight Delivery Vendor: _____/_____/_____

Date MAXIMUS CHDR should expect Delivery: _____/_____/_____

Brief Description of Denied Services:

APPENDIX A

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

PACE ORGANIZATION RECONSIDERATION PROJECT

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

For use to submit a new PACE Organization Reconsideration Project case file for review by MAXIMUS CHDR. MAXIMUS CHDR will not accept a new case file submitted via facsimile. MAXIMUS CHDR will not initiate new cases submitted via facsimile until the hard copy is received.

Expedited Case File Materials? YES_____ NO_____

Member Name: _____

Member HIC Number: _____

Document	Check if submitted
Reconsideration Background Data Form **Case will not be initiated until the completed Reconsideration Background Data Form is received by MAXIMUS CHDR*	
Case Narrative	
Organization Determination and Reconsideration Process Notices	
Records of Adverse Determination	
PO Decision Making Criteria	
Medical Records (if applicable)	

APPENDIX A

REQUEST FOR INFORMATION RESPONSE COVER SHEET

PACE ORGANIZATION RECONSIDERATION PROJECT

REQUEST FOR INFORMATION RESPONSE COVER SHEET

For use to submit case file specific information in response to a MAXIMUS CHDR Request for Information. Please do not send documents containing confidential information via facsimile.

Expedited Case File Materials? YES_____ NO_____

Member Name: _____

MAXIMUS CHDR Case Number: _____

APPENDIX A
STATEMENT OF COMPLIANCE FORM

PACE ORGANIZATION RECONSIDERATION PROJECT

STATEMENT OF COMPLIANCE FORM

Enrollee Name	
PACE Organization Contact	
MAXIMUS CHDR Case #	
PACE Organization Name	
PACE Organization Contract #	
Effectuation Date	
Authorization # or Check #	

If you have questions regarding a MAXIMUS CHDR Reconsideration Determination, please contact the MAXIMUS CHDR Project Director for the Medicare Managed Care & PACE Reconsideration Project.

Please note MAXIMUS CHDR cannot waive compliance with a MAXIMUS CHDR Reconsideration Determination. If you feel that you cannot comply with the MAXIMUS CHDR Reconsideration Determination, you must notify your Team Leader at the CMS Regional Office.

MAXIMUS CHDR Admin. Use Only

Log _____ File _____

APPENDIX A
REOPENING REQUEST FORM

PACE ORGANIZATION RECONSIDERATION PROJECT

REOPENING REQUEST FORM

Enrollee Name: _____

MAXIMUS CHDR Reconsideration Case Number:_____ - _____

Dates of Service:_____ - _____

PO Name: _____

PO Contact: _____

Contact Title: _____

Street Address: _____

Mail Stop: _____

City/State/Zip: _____ _____ _____

Telephone Number: _____ Ext.: _____

Fax Number: _____ Date of Request: _____/_____/_____

Basis of Reopening Request:

- ☐ Error on the face of the evidence
- ☐ New and material evidence
- ☐ Fraud

Explain briefly: