



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals
**PETITION TO OBTAIN APPROVAL OF A FEE
FOR REPRESENTING A BENEFICIARY**

Instructions: An attorney or other appointed representative for a beneficiary must request and obtain approval to charge a fee for services rendered in connection with an appeal before the Office of Medicare Hearings and Appeals (OMHA), **unless** a fee arrangement was made for purposes of making a claim for third party payment. A fee arrangement made to represent a beneficiary in a claim for third party payment does not require approval, even if the representation ultimately includes a Medicare Secondary Payer recovery claim. A representative must submit a fee petition to the assigned Administrative Law Judge (ALJ) no later than 60 days after the date the notice of decision, dismissal, remand, or escalation was mailed, and must provide a copy to the beneficiary.

Section 1: What is your (the representative's) information? (Beneficiary information in next section)

Name	Firm or Organization (if applicable)	Telephone Number
Mailing Address	City	State ZIP Code

Section 2: What is the beneficiary's information?

Name	Health Insurance Claim Number (HICN)	Telephone Number
Mailing Address	City	State ZIP Code

Section 3: Representative and fee information: To be completed by the representative.

- Are you an attorney? ☐ No ☐ Yes
- Have you ever been disbarred or suspended from a court or bar to which you were previously admitted? ☐ Not applicable (I am not an attorney) ☐ No ☐ Yes
- Have you been disqualified from participating in or appearing before a Federal program? ☐ No ☐ Yes
- Have you and your client entered into a fee agreement for services provided in connection with an appeal before OMHA (if yes, please attach a copy)? ☐ No ☐ Yes
- Itemized list of services: **On a separate page or pages**, itemize the services you rendered in connection with an appeal before OMHA. List each meeting, conference, item of correspondence, telephone call and other activity in which you engaged (such as research, preparation of a brief, attendance at a hearing, or travel) related to your services as a representative in this case. Please provide the date, description, and actual amount of time spent on each service, and the total number of hours. For services not yet rendered, include the expected number of hours and hourly rate, plus any retainer. For a contingency fee, please describe the terms.

- Complete the following statement: I request approval to charge a total fee (actual and anticipated) of \$_____ for services rendered before OMHA as the appointed representative of the Medicare beneficiary identified above, in connection with the following OMHA Appeal Number(s):

By signing this document, I verify that all statements made in this fee petition and any accompanying documents are true and accurate, to the best of my knowledge.

Representative Signature	Date
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Section 4: OPTIONAL beneficiary agreement: You (the representative) may ask the beneficiary to sign this petition and indicate agreement with the fee amount. The beneficiary should mark **one** of the following choices and sign below.

- ☐ I agree with the \$_____ fee, which my representative is asking to charge and collect. By signing this request, I am not giving up my right to later disagree with the total amount approved by the ALJ.
- ☐ I do not agree with the requested fee or other information given here, or I need more time.

As the beneficiary, I understand that I do not have to sign this petition, and that it is my right to disagree with the amount of the fee requested or any information given.

Beneficiary Signature	Date
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Privacy Act Statement

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

If you need large print or assistance, please call 1-855-556-8475

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Glossary

This glossary explains terms found on the omha.hhs.gov web site, but it is not a legal document.

A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V |
W | X | Y | Z

A

Adjudicator: The person who makes the decision in an appeal. There is an adjudicator at each of the five levels of Medicare appeals. In OMHA, the adjudicator of an appeal is the Administrative Law Judge (ALJ) or an attorney adjudicator.

Adjusted annually: A change that occurs on a yearly basis.

Administrative Law Judge (ALJ): An Administrative Law Judge (ALJ) is an independent decision-maker who is authorized to preside over hearings and render legally binding decisions. In the Medicare appeals process the ALJ is an adjudicator at OMHA, the third level of the claim appeals process. At OMHA, the ALJ presides over

the hearing by administering oaths, taking testimony, ruling on questions of evidence and making factual and legal determinations. In issuing his or her decision, the OMA ALJ is bound by the Administrative Procedure Act, Medicare statutes and regulations, precedential decisions of the Medicare Appeals Council, and national coverage determinations and rulings issued by Centers for Medicare and Medicaid Services (CMS).

Advance Beneficiary Notice (ABN): An Advance Beneficiary Notice (ABN) is a letter officially informing you that your healthcare provider or supplier believes that Medicare will not cover an item(s) and/or service(s). The ABN helps you make an informed choice about whether or not you want to receive the item(s) and/or service(s) knowing that you may be responsible for payment. Remember, if you decide to receive the item(s) and/or services, you may be financially responsible for those charges.

ALJ hearing: An ALJ hearing is an official proceeding for an administrative appeal. For Medicare, an ALJ hearing takes place at the third level of appeal where the ALJ hears arguments and takes testimony to determine if a medical service or item is covered by Medicare or an individual is entitled to Medicare benefits. In the Medicare appeals process, an ALJ hearing can only take place after the first two levels of appeals have been completed.

Amount in controversy: The threshold dollar amount remaining in dispute that is required for an ALJ hearing at level 3 of the Medicare appeals process. The AIC is recalculated and published on an annual basis, and is identified in your reconsideration or reconsideration determination.

Appeal: For Medicare purposes, an appeal is the process used when a party, e.g., beneficiary, provider or supplier, disagrees with a decision to deny or stop payment for healthcare items or services or a decision denying an individual's enrollment in the Medicare program.

Appellant: A beneficiary, provider, supplier or other entity that submits an appeal of a particular Medicare initial determination. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Appointed Representative: An individual a party selects to assist in pursuing a Medicare claim or appeal. An appointed representative can include the beneficiary's family member, friend, lawyer or the provider or supplier that furnished the Medicare items or services.

Associate Chief Administrative Law Judge (ACALJ): In OMHA, the ACALJ reports to the Chief Administrative Law Judge and supervises the Administrative Law Judges within his or her respective field office.

Attorney Adjudicator: A licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, and authorized to take action on requests for ALJ hearing and requests for reviews of QIC dismissals. See 42 C.F.R. § 405.902.

Authorized Representative: An individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. An authorized representative has all the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process. Examples of an "authorized representative" include a court-appointed guardian, an individual with durable power of attorney, and an individual designated under a State health care consent statute.

B

Beneficiary: An individual who is enrolled to receive benefits under the Medicare program. See 42 C.F.R. § 405.902.

C

Carrier: A private company that has a contract with the Centers for Medicare and Medicaid Services (CMS) to determine and make Medicare payment for Part B items and services. As part of the mandatory Medicare Contract Reform, CMS is currently replacing Medicare Carriers with Medicare Administrative Contractors. (See also "Medicare Administrative Contractors".)

Centers for Medicare and Medicaid Services (CMS): The federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program. Among its responsibilities, CMS oversees the Medicare Administrative Contractors involved in the processing and review of Medicare claims at the first and second level of appeals.

Chief Administrative Law Judge: The Chief Administrative Law Judge is the head official of OMHA and oversees all OMHA operations and personnel.

Claim: A claim is a request for payment for items and services billed under the Medicare program.

Coverage determination: A decision by a Medicare Part D plan sponsor not to provide or pay for a Part D drug that the enrollee believes may be covered by the plan. See 42 C.F.R. 423.566.

D

Departmental Appeals Board (DAB): A Board established in the Office of the Secretary of HHS whose members act in panels to provide impartial review of disputed decisions made by operating components of the Department or by ALJs. The Medicare Appeals Council is a division of the DAB. Note, this is the regulatory definition. See 42 C.F.R. § 400.202.

E

Enrollee: An individual who is eligible for and has elected or has enrolled in a Medicare Part D Prescription Drug plan or Medicare Advantage (MA) Plan.

Entitlement Appeals: The process pertaining to an individual's application to enroll in the Medicare program and receive Medicare benefits.

Evidence: Information presented throughout the appeals process for the purpose of establishing the truth or falsity of an alleged matter of fact. This may include the testimony of witnesses, records, documents or objects.

F

Fiscal intermediary: A private company that had a contract with CMS to determine and make Medicare payment for Part A benefits and certain Part B benefits. As part of the mandatory Medicare Contract Reform, CMS was directed to replace Fiscal Intermediaries with Medicare Administrative Contractors. (See Medicare Administrative Contractors). See 42 C.F.R. § 405.902.

H

Hearing: See "ALJ Hearing".

Health Insurance Claim Number (HICN): The number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary, prior to April 1, 2018. Starting on April 1, 2018, this number was replaced by the Medicare Beneficiary Identifier (MBI) (See Medicare Beneficiary Identifier).

Hospital Insurance Benefits (Medicare Part A): The Hospital Insurance benefits help pay for inpatient hospital services, post hospital skilled nursing facility care, home health services and hospice care.

I

Income-Related Monthly Adjustment Amount (IRMAA): The additional amount of premium that a beneficiary will pay for Medicare Part B coverage based on income above a certain threshold. The income-related monthly adjustment amount is based on a beneficiary's modified adjusted gross income.

Initial determination (Entitlement Appeals): A determination made by the Social Security Administration (SSA) pertaining to an individual's application for Medicare benefits and/or entitlement to receive Medicare benefits under Part A and/or Part B of the Medicare program.

Initial determination (Claim Appeals): Following a receipt of a claim for payment, a determination issued by the Medicare Administrative Contractor indicating whether the item or service is covered and otherwise reimbursable under the Medicare

program, and the amount of payment due.

M

Medicare Advantage Plan (MA plan): Health benefits coverage offered under a policy or contract by an MS organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan.

Medicare Advantage Program (Part C): The program under Part C which provides all Part A and Part B services as well as additional services in some cases through Medicare Advantage health plans.

Medicare Administrative Contractor: The entity contracted with CMS that is responsible for the receipt, processing and payment of Medicare service claims under the Original Medicare Part A and Part B programs. In addition to providing claims processing, these contractors will be the primary contact for physicians and perform functions related to: Appeals, Provider Outreach and Education, Financial Management, Provider Enrollment, Reimbursement, Payment Safeguards, and Information Systems Security. As part of the Medicare Contract Reform, CMS was directed to replace Fiscal Intermediaries and Carriers with Medicare Administrative Contractors.

Medicare Appeals Council: A division within HHS Departmental Appeals Board that reviews and hears cases following an OMHA adjudicator's decision pertaining to Medicare claims and entitlement appeals.

Medicare Beneficiary Identifier (MBI): A unique, randomly-generated number shown on a beneficiary's Medicare card and used in processing claims for that beneficiary. The MBI is 11 characters in length and is made up of numbers and uppercase letters. The MBI is also known as a beneficiary's Medicare Number.

Medicare Number: Another name for the Medicare Beneficiary Identifier (MBI), which replaced the Health Insurance Claim Number (HICN) on all Medicare cards beginning on April 1, 2018 (See Medicare Beneficiary Identifier). This number is

shown on a beneficiary's Medicare card and is used in processing claims for that beneficiary.

Medicare Prescription Drug Plan: A prescription drug plan offering prescription drug coverage under a policy, contract, or plan. See *42 C.F.R. § 423.4*.

Medicare Prescription Drug Program (Part D): The program under Part D of the Medicare statute that provides coverage for Part D drugs. Enrollees obtain prescription drugs through Medicare Prescription Drug Plans.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): This 2003 legislation provided Medicare eligible seniors and individuals with disabilities with a prescription drug benefit. The MMA also authorized OMHA's creation.

N

Notice of Decision: A document that notifies the parties of the written decision of the OMHA adjudicator. The notice of decision gives findings of fact, conclusions of law and the reasons for the decision. The notice of decision also provides information about the right to appeal the decision to the Council. See *42 C.F.R. § 405.1046(a)*.

Notice of Dismissal: A document that notifies the parties of the written dismissal of the hearing or review request issued by the OMHA adjudicator. The notice of dismissal provides information about the right to appeal the dismissal to the Council or request the OMHA adjudicator vacate the dismissal. See *42 C.F.R. § 405.1052(d)*.

Notice of Remand: A document that notifies the parties of the written remand of the hearing or review request issued by the OMHA adjudicator. The notice of dismissal provides information about the right to request that the Chief ALJ or a designee review the remand. See *42 C.F.R. § 405.1056(f)*.

O

On the record: An appeal in which the issues are decided based solely on the documentary evidence and without an oral hearing. In OMHA, a party can waive its right to an oral hearing and request the case be decided on the record. An ALJ may decide a case on the record when all parties who would be sent a notice of hearing indicate in writing that they do not wish to appear at an oral hearing. The ALJ may also decide a case on the record when the documentary evidence supports a finding fully favorable to the appellant(s), no other party to the appeal is financially responsible for any of the claims at issue, and CMS has not elected party status in the appeal. See 42 C.F.R. § 405.1038.

Organization Determination: A determination regarding the benefits an enrollee is entitled to receive under an MA plan. The organization determination is made by an MA plan under Part C of the Medicare program. See 42 C.F.R. § 422.566.

Original Medicare: Health insurance available under Medicare Part A and Part B through the traditional fee for service payment system.

P

Party: An individual or entity listed in 42 C.F.R. § 405.906 that has standing to appeal an initial determination and/or a subsequent administrative appeal determination. This can include a beneficiary, a provider, a supplier, or a Medicaid State agency.

Provider: A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that has in effect an agreement to participate in Medicare, or clinic, rehabilitation agency or public health agency that has in effect a similar agreement, but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. See 42 C.F.R. § 405.902.

Q

Qualified Independent Contractor (QIC): An entity that has a contract with the Centers for Medicare and Medicaid Services (CMS) to review appeals following a redetermination by a Medicare Administrative Contractor and reconsiderations issued by Quality Improvement Organizations. QICs issue reconsiderations and represent level 2 of the Medicare appeals process.

Quality Improvement Organization (QIO): An entity that has a contract with CMS to monitor the appropriateness, effectiveness and quality of care furnished to Medicare beneficiaries. A QIO makes determinations as to whether the services provided were medically necessary and responds to beneficiary's complaints about the quality of care provided.

R

Reconsideration: The decision made in the second level of the Medicare appeals process. A reconsideration consists of an independent on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim. A reconsideration is conducted by a QIC or QIO under Medicare Parts A and B, by an Independent Review Entity or QIO under Part C, by an Independent Review Entity under Part D, and by the Social Security Administration for Medicare entitlement and certain premium appeals.

Reconsidered Determination: In Part C cases, an on-the-record decision issued by an Independent Review Entity following an adverse organization determination, in whole or in part.

Redetermination: An independent review of an initial determination. A redetermination is conducted by the same Medicare contractor that issued the initial determination and refers to the decision made in the first level of the Medicare appeals process.

Regulation: A rule or order established by a government agency in accordance with the Administrative Procedure Act.

S

Supplementary Medicare Insurance Program (Part B): The Medicare program that pays for a portion of the costs related to physicians' services, outpatient hospital services, ambulance services, laboratory tests, wheelchairs, hospital beds and other medical and health related services not covered by Medicare Part A for voluntarily insured aged and disabled individuals.

Supplier: A physician or other practitioner, a facility or other entity (other than a provider of services) that furnishes items or services under Medicare. See 42 C.F.R. § 405.902.

V

Video teleconference (VTC): A meeting where those attending view and hear each other with the use of video cameras and televisions from different locations.

W

Witness: A person who testifies under oath at a hearing and who provides firsthand or expert evidence.

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