MAXIMUS Federal Services

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

REOPENING REQUEST FORM

Enrollee Name: _____

MAXIMUS Federal Services Reconsideration Case Number: _____

Dates of Service: _____

Medicare Health Plan Name: _____

Medicare Health Plan 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: