**Notice of Dismissal of Appeal Request**

**Date:**

**Enrollee Name: Enrollee ID Number:**

Health Plan Name: Phone: Fax:

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.)*

**What to do next**

**If you disagree with our decision to dismiss your appeal request,** you have two options:

1. **You can ask us to set aside (vacate) the dismissal action.** If we determine there’s 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’ll vacate our dismissal and review your coverage request again. We must get your request at <*insert address/fax/phone>* within **6 months** of the date on this notice. Include a copy of this notice and any supporting information with your request.
2. **You also have the right to ask an independent reviewer contracted with Medicare to review our decision**. If the independent reviewer agrees that your appeal should not have been dismissed, your appeal request will go back to <*Insert plan name>* for processing.

If you want an independent reviewer to review our decision, you must send your request within **65 calendar days** of the date of this notice. **Include a copy of this Notice of Dismissal of Appeal Request** along with any supporting information you want the independent reviewer to consider. The independent reviewer will send you a notice of its decision.

Submit your written request by mail, fax or electronically:

**Online:** [c2cinc.com//Appellant-Signup](https://www.c2cinc.com/Appellant-Signup)

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

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| **Mail:**  C2C Innovative Solutions, Inc.  Part D Drug Reconsiderations  P.O. Box 44166  Jacksonville, FL 32231- 4166 | **UPS / FedEx**:  C2C Innovative Solutions, Inc.  Part D Drug Reconsiderations  301 W. Bay St., Suite 1110  Jacksonville, FL 32202 |

**Get help and more information**

**For questions** about this notice, contact (*Insert plan name*) at toll-free at (*insert Toll Free Phone*) on (*days & hours of operation*). TTY users can call (TTY phone).