Department of Health and Human Services
Centers for Medicare & Medicaid Services

Request for Retrospective Appeal of Medicare Part A Coverage

If you're a Medicare patient who was admitted to the hospital as an inpatient, and the hospital changed your status to an outpatient receiving "observation services" that weren't covered by Medicare Part A, you may be able to appeal. If eligible, you can appeal hospital stays as far back as January 1, 2009.

If your appeal decision is favorable, Medicare Part A may cover the hospital and/or skilled nursing facility services you got. You may also be entitled to a refund for payments you or a family member made for denied services. We must receive your appeal request by January 2, 2026.

Answer 4 questions about your hospital stay to help you decide whether you may qualify for an appeal:

1. Were you admitted to the hospital as an inpatient on or after **January 1, 2009**, and did the hospital change your status to outpatient during your stay?

◯ Yes ◯ No

2. Did you receive observation services in the hospital **after** the hospital changed your status to outpatient?

◯ Yes ◯ No

3. Did you get a Medicare Summary Notice (MSN) for outpatient services for your hospital stay **OR** a Medicare Outpatient Observation Notice (MOON) for observation services during your hospital stay?

◯ Yes ◯ No

4. Is this the **first time you're appealing** for Medicare to cover services related to this hospital stay **OR** if you did appeal, did you get a decision AFTER September 4, 2011?

◯ Yes ◯ No

If you answered YES to all 4 questions above, you can use this form to ask for an appeal if at least one of these statements also applies to you:

- Medicare denied coverage for the costs of your hospital stay as an outpatient because you didn't have Medicare Part B while you were in the hospital.

  OR

- You stayed in the hospital for 3 or more consecutive days but were an inpatient for less than 3 days, and you were admitted to a skilled nursing facility within 30 days after you left the hospital.

If you think you may be eligible, complete the form on the next 4 pages. We'll review your request and any records we can get to determine if you're eligible for this appeal.

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Patient information

Only people with Original Medicare, their appointed/authorized representative, someone filing on behalf of their estate, or someone with legal authority to file on behalf of a deceased beneficiary can file an appeal using this form.

Note: Providers, suppliers, Medicaid state agencies, or other insurers can't submit an appeal request on behalf of a beneficiary as their representative. **People who were enrolled in a Medicare Advantage plan at the time of hospitalization aren't eligible for an appeal under this process.**

Patient name	Medicare Number ____-___-____	
Address		
City	State	ZIP code
Email address (optional)	Phone number (optional) (___)___-____	
Hospital name	Hospital location (city & state)	
Dates of hospitalization (mm/dd/yyyy) __/__/____ – __/__/____		

Optional: Explain below (or attach another sheet) why you think Medicare Part A should have covered your hospital services as an inpatient:

Did you (or a friend or family member) pay out of pocket for skilled nursing facility services after this hospital stay? If yes, complete this section.

Skilled nursing facility name	Facility location (city & state)
Dates of facility stay (mm/dd/yyyy) __/__/____ – __/__/____	
Amount paid to facility $	Date of payment(s) to facility __/__/____

Signature

I, ______________________________ (print full name), hereby attest that the information given here is accurate to the best of my knowledge. In addition, I attest that the charges for the skilled nursing facility services listed above were paid for by the named beneficiary, or by a family member or friend on behalf of the named beneficiary. I'm sending proof of payment with my request (for example, a canceled check showing payment to the skilled nursing facility for the services, a bill from the skilled nursing facility showing the payment I made, etc.).

Signature	**Date** (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __

What to submit with this form

With your signed form, submit copies of any information you have about your hospital stay and/or the skilled nursing facility services you received. This includes things like:

- **All medical records from your hospital stay and if applicable, the skilled nursing facility stay.** Ask the hospital and the skilled nursing facility (if part of your appeal) for these records. If you can't send the records with this form, we'll try to get them. If we have to ask the hospital and/or skilled nursing facility for the records, they have 120 days to respond.
- **The Medicare Summary Notice (MSN) from your hospital stay.** This is the document from Medicare that lists the claims submitted for your medical care. You may be able to get a copy of your MSN by logging into your Medicare account at **Medicare.gov**, or calling 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.
- **The Medicare Outpatient Observation Notice (MOON)** from your hospital stay (if you got one). This is a document you get from the hospital if you receive observation services as an outpatient for more than 24 hours. Hospitals started using this notice in March 2017.
- **Any bills or itemized statements from the hospital.**
- **The MSN from the skilled nursing facility stay** (if your skilled nursing facility submitted a claim to Medicare). If the skilled nursing facility didn't submit a claim to Medicare, send the itemized bill from the skilled nursing facility (if you were billed for skilled nursing facility services).
- **Proof of payment for skilled nursing facility services** showing that you or a family member or friend paid for skilled nursing facility services, and sign the statement on page 2 about your out-of-pocket payments for those services.
- Any additional evidence you think will help your appeal.

Submit this form by mail or fax

Submit this completed form and any records or evidence as soon as possible. Your request must be received no later than **January 2, 2026**.

Fax: 803 278 - 9541

Mail: Q2 Administrators – CMS 4204-F Appeals
300 Arbor Lake Drive, Suite 1350
Columbia, SC 29223-4582

What happens next

- We'll review the documents you submit and any information we can get from your provider(s) to determine if you're eligible to appeal.
- We may contact you by mail if we need more information from you.
- We'll notify you of our decision about your eligibility for an appeal by mail, usually no later than 60 days after we gather all the records.
- For questions about this form, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. If you need an accessible format, tell us what format here: ______________________________________ . For more information, call 1 800 633 - 4227. TTY users can call 1 877 486 - 2048.

You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1 800 633 - 4227 for more information. TTY users can call 1 877 486 - 2048.

Privacy Act Statement: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. 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 request. Information you furnish on this form may be disclosed by the Centers for Medicare & Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws.