Medicare Advantage Plan Appeals Guidelines November 2026

In recent months, two different cases of a Medicare Advantage Plan (Medicare Part C) asking for a specific form signed by a patient when a provider needs to file a claims appeal have been reported. This is a requirement that is a bit unique to Medicare Part C (and Part D).

This requirement under Part C, is defined in §422.561 of the Medicare law. It states that an individual must be appointed by a patient (or other party, or authorized under state or other applicable law) to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Any individual can be designated as a patient representative (e.g., provider, relative, friend, advocate, attorney) when Form CMS-1696, Appointment of Representative (AOR), (or an equivalent) written notice is signed by the patient and the designated representative. Form CMS 1696 is valid for one year unless it is revoked. This form is separate from the typical forms practice have signed when granting permission to file claims to insurance.

The typical forms signed by patients include any general consent for treatment, practice financial policy acknowledgements, HIPAA privacy notices, and assignment of benefits that are required by either the provider's practice or the health plan. Providers may include the CMS Form 1696 when the patient is initially seen in the practice or at any time it is required; however, this form must be renewed annually and must be sent in when any appeal is necessary.

The Part C Medicare plan must make efforts to get the appropriate forms signed. Any appeal or grievance can be dismissed without action if person or entity making the request does not obtain the appropriate CMS-1696 (or equivalent) signed form. In other words, the standard assignment of benefits alone does not automatically constitute designation as an authorized representative in the event an appeal of a claim is necessary.

In another twist to the Medicare Part C regulations is that if a provider is a non-contracted provider with a specific plan and the Medicare Part C plan denies a request for payment to said non-contract provider, the non-contract provider may independently pursue an appeal if a Waiver of Liability (WOL) statement is filed without the patient signing the Appointment of representative (AOR) form. The WOL statement provides that the non-contract practitioner will not bill the MA enrollee regardless of the outcome of the appeal. The WOL forms states that the provider will not attempt to collect any payments from the patient if the appeal is unsuccessful.

Happy coding….

References:

Medicare Appeals: https://www.medicare.gov/publications/11525-medicare-appeals.pdf
Medicare Advantage Plan Appeals: https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf
Appointment of Representative Form: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf
Appeals Process: https://college.acaai.org/medicare-advantage-appeals-process-explained/
Managing Medicare Appeals: https://www.ehealthinsurance.com/medicare/managing-medicare/medicare-appeals/
Waiver of Liability https://www.uhcprovider.com/content/dam/provider/docs/public/claims/WOL.pdf
Medicare MLN Appeals: https://www.cms.gov/files/document/mln006562-medicare-parts-b-appeals-process.pdf