

MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM
C2C CASE NUMBER _____

1. CASE PRIORITY:

- Expedited
- Standard Service (Pre-authorization)
- Standard Claim (Reimbursement)
- Standard Service Part B Drug request (Pre-authorization)

2. DATE(S) OF SERVICE IN QUESTION: _____

3. PLAN'S DISMISSAL REASON

- Untimely Filing of Appeal
- Waiver of Liability missing
- Not an Authorized Rep
- Not a Valid Rep of Estate
- Other _____

4-a. ENROLLEE DATA

Enrollee Name: _____ HIC/MBI: _____ Enrollee Phone: _____
 Street Address: _____ City: _____ State: _____ Zip: _____

Does the Enrollee require the Dismissal Determination Notice in a language other than English? No Yes _____ (specify language)

Does the Enrollee require communication be made in any alternate format?

No Yes _____ (specify type of format below)

Large Print (if other than 18-point font, indicate size below) Audio CD Braille Qualified Reader

Other _____ (specify type of format or font)

4-b. REQUESTOR DATA (i.e., person/entity requesting the dismissal review) (check one)

Enrollee
 Enrollee's Treating Physician
 Enrollee's Estate
 Non-Contract Provider
 Representative
 Surrogate acting in accordance with State Law

Name of Requestor: _____ Phone: _____
 Street: _____ City: _____ State: _____ Zip: _____

5. MEDICARE HEALTH PLAN (MHP) DATA

CMS CONTRACT # (REQUIRED): _____ Plan Name: _____
 Street: _____ City: _____ State: _____ Zip: _____

6. MHP CONTACT PERSON FOR THIS DISMISSAL REVIEW

Contact Person Name: _____ Email: _____ Phone: _____
 Decision Fax Number: _____
 Alternate Contact Person or Supervisor Name: _____ Phone: _____

7. Please indicate if the following documents are included in the dismissal case file:

a. Correspondence of attempts to get representative documentation/WOL (if applicable)	Yes	No
b. Notice of Dismissal	Yes	No
c. Appeal Letter (or phone records if an expedited request was made)	Yes	No
d. Documentation regarding the Plan's assessment of good cause (if applicable)	Yes	No