Medicare Managed Care Reconsideration Background Data Form

1. Case Priority:

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

2a. Amount in Controversy: $_____

2b. Date(s) Of Service in Question:_____

2c. Does This Case Involve a Cost Sharing Issue? ◯Yes ◯No

2d. Is This Case an Auto Forward? ◯Yes ◯No

2e: Does This Case Involve a Denial Due to Medical Necessity ◯Yes ◯No

3. Enrollee Data

Enrollee Name:_____ HIC:_____

Enrollee Street:_____ MBI:_____

Enrollee City:_____State:_____ Zip:_____ Enrollee Phone:_____

Is the Enrollee Deceased? ◯No ◯Yes - Date of Death_____

Is the Enrollee in Hospice? ◯No ◯Yes - Date of Election_____(election form must be provided)

Does the Enrollee require the final 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) _____

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

☐Other (specify type of format or font)

4. Appeal Requestor Data (check one)

- ◯ Enrollee is Requestor
- ◯ Enrollee's treating physician (no AOR required for Expedited or Standard Item/Service cases)
- ◯ Enrollee's Estate Is Estate Documentation in File? ..... ◯Yes ◯No
- ◯ Non-Contract Provider (payment cases only) Is a Waiver of Liability in File? ..... ◯Yes ◯No
- ◯ Representative Is an AOR or Power of Attorney in File? ..... ◯Yes ◯No
- ◯ Surrogate acting in accordance with State Law..... ◯Yes ◯No

Name of Requestor:_____ Phone:_____

Company Name:_____ City:_____

Street:_____ State:_____ Zip:_____

5. Medicare Health Plan (MHP) Data

CMS Contract # (required):_____

Plan Name:_____

Plan Type: ☐ HMO ☐ PSO ☐ Demo ☐ MMP ☐ MSA ☐ HCPP ☐ SNP ☐ Cost
☐ Local PPO ☐ Regional PPO ☐ PFFS ☐ PACE ☐ MMP-NY FIDA

Address for Appeal Correspondence:

Street:_____

City:_____ State:_____ Zip:_____

6. MHP Contact Person for This Reconsideration

Contact Person Name:_____ Email:_____

Phone:_____ RI Fax Number:_____ Decision Letter Fax Number: _____

Alternate Contact Person or Supervisor Name:_____ Phone:_____

7. MHP Organization Determination (Complete for all cases)

a. Date of Initial Authorization request or claim submission .....

b. Date of Plan's initial Denial (Organization Determination) .....

c. Was an Expedited request made? ..... ◯ Yes ◯ No

d. Was the expedited request granted? ..... ◯ Yes ◯ No

e. Did the plan take an extension? (If so, please provide notice in file) ◯ Yes ◯ No

8. MHP Reconsideration (Complete for all cases)

a. Date of Reconsideration Request .....

b. Date of Plan's Reconsideration Determination .....

c. Was an Expedited request made? ..... ◯ Yes ◯ No

d. Was the expedited request granted? ..... ◯ Yes ◯ No

e. Did the plan take an extension? (If so, please provide notice in file) ..... ◯ Yes ◯ No

9. Provider Identification Data (Please list all providers applicable to this appeal, including referring providers)

Provider Name(s):	Specialty:	Records Requested	Records Provided	Contract Provider
1. _____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
2. _____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
3. _____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. _____	_____	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Services received/requested outside of the MHP's geographic service area?..... ◯ Yes ◯ No

Services received/requested outside of MHP's network of providers?..... ◯ Yes ◯ No

Services received/requested outside of Enrollee's medical group? ..... ◯ Yes ◯ No ◯ N/A

10. Definition of Denied Services or Claims

Item/service in dispute _____

Enrollee's condition related to the Item/Service in dispute:_____

_____

_____

Enrollee's ICD-9/10 diagnosis code(s) applicable to the issues in this case: ....._____

_____

_____

_____

HCPCS/CPT codes representing the items/services in dispute ..... _____

(Please do not substitute revenue codes for outpatient hospital services) _____

_____

_____

11. Please indicate if the following documents are included in the file:

a. Organization Determination Notice with Appeal Rights	◯ Yes	◯ No
b. Notice of Appeals Status/Closure Letter	◯ Yes	◯ No
c. Appeal Letter (or phone records if an expedited request was made)	◯ Yes	◯ No
d. Evidence of Coverage (EOC): *Note: we encourage Plans submitting case files outside of the Portal to send the EOC in an electronic format on a CD or Thumb Drive. PDF format is preferable.*	◯ Yes	◯ No
e. Criteria Used to Reach Decision	◯ Yes	◯ No
f. Medical Records (legible)	◯ Yes	◯ No
g. Original X-Rays, Digital X-Ray Prints, Photographs	◯ Yes	◯ No