

PACE ORGANIZATION RECONSIDERATION BACKGROUND DATA FORM

I. Case Class:

- Expedited
- Standard Service (Pre-authorization)
- Standard Claim (Reimbursement)

II. Identifying Data — Enrollee

Enrollee Name: _____
Medicare (HIC)#: _____ / Medicare (MBI) #: _____
Mailing Address: _____
Telephone #: _____ ZIP: _____
City: _____ State: _____
Is Enrollee Deceased? Yes No
Does the Enrollee require the final decision in a language other than English? Yes No
If Yes, please indicate required 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) _____

Designated Representative Information (Complete if Enrollee has a Designated Representative for Reconsideration)

Name: _____ Telephone #: _____
Mailing Address: _____
City: _____ State: _____ ZIP: _____

III. PACE Organization Information

PO Name: _____ CMS Contract #: _____
Mailing Address: _____ Plan Type: PACE
Organization
City: _____ State: _____ Zip: _____
Plan Contact: _____
Phone: _____ FAX: _____
Best time to contact (Eastern Time): _____ Email: _____

IV. PACE Organization Processing Data

IV(A). Organization Determination

- 1) Date Request for Service Determination made: _____
- 2) Did the PO take the up to a 5-day extension? Yes No
- 3) Date Service Determination made: _____

IV(B). PO Appeal Decision

- 1) Date Request for PO Appeal made: _____
- 2) Was the request for an Expedited PO Appeal? Yes No
- 2) If request was for an expedited decision, did the PO take the up to a 14-day extension? Yes No
- 3) Date PO Appeal Decision made: _____

IV(C). Request for IRE Review

- 1) Date Request for IRE Review made: _____
- 2) Was the request for an Expedited IRE Reconsideration? Yes No
- 3) Date PO Case File prepared and sent: _____

V. Description of Item or Service in Dispute

V(A). Definition of Denied Items

Item No.	Description of Item or Service in Dispute	Estimated \$ Amount in Dispute	Denied Dates of Service
1			
2			
3			

V(B). Provider Identification

Complete a line for each provider described in case. Do not limit to denied service if a provider is referenced for other purposes, such as role in referral or claim denial process.

Provider	Specialty	Type	Relation to PO	Medical Records
1				
2				
3				

Codes:	Type	Relation to PO	Medical Records
	1. Hospital 2. SNF 3. Other Facility 4. Freestanding Clinic 5. Home Health Agency 6. Practitioner/Professional	A. PCP/Enrollee's Primary Care Center B. Other PO Provider, in Network C. Non Plan Provider, but under Referral from PO D. No Relationship to PO	1. Included 2. Not Applicable 3. Not Requested 4. Requested/Refused

VI. Attestation

I certify on behalf of the PACE Organization defined in Section III, above, that the information on this form and submitted with this case is to the best of the organization's knowledge the true, accurate and complete record of the appeal available to the organization at this time.

Signed: _____

Print Name: _____

Date: _____