C2C INNOVATIVE SOLUTIONS, INC.
Integrity, Quality & Value – Coast to Coast

APPENDIX: Part C QIC MEDICARE HEALTH PLAN RECONSIDERATION PROCEDURES MANUAL FORMS & INSTRUCTIONS

MAY 2026, VERSION 1.1

Forms & Instructions Included in this Appendix:

1. *Instructions for Reconsideration Background Data Form and Case Narrative*
2. *Reconsideration Background Data Form*
3. *Instructions for Dismissal Case File Data Form Following IRE Request for Dismissal Case File and Dismissal Case Narrative*
4. *Dismissal Case File Data Form*
5. *Plan Response to IRE Request for Additional Documentation Transmittal Cover Sheet*
6. *Statement of Compliance Form-IRE Reconsideration Decision*
7. *Plan Reopening Request Form*
8. *Statement of Compliance Form – Administrative Law Judge (ALJ) Decision*
9. *Statement of Compliance Form – Medicare Appeals Council (MAC) Decision*
10. *New Case File Transmittal Cover Sheets for Reconsiderations and IRE Review of Plan Dismissal Case Files Submitted to IRE Outside of the QIC Appeals Portal*
11. *Plan Submission of Additional Information Authorizing Coverage or Payment for an Item, Service, or Part B Drug Subsequent to the Plan Submission of the Case and Case File to the IRE for Processing of the IRE Reconsideration*
12. *Key Plan Organizational Contact Form*

SECTION 1:
INSTRUCTIONS FOR THE RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

INSTRUCTIONS FOR COMPLETION OF: MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM AND CASE NARRATIVE

I. GENERAL ORGANIZATION OF SUBMITTED NEW CASE FILE MATERIAL

Consult the C2C Innovative Solutions, Inc. (C2C) *Medicare Health Plan Reconsideration Procedures Manual* for general instructions on IRE Reconsideration case file development. The instructions that follow apply to completion of the mandatory:

- Reconsideration Background Data Form
- Case Narrative

II. INSTRUCTIONS FOR COMPLETION OF THE RECONSIDERATION BACKGROUND DATA FORM

The Medicare Health Plan must submit a completed Medicare Managed Care Reconsideration Background Data Form (RBDF) with **each** new IRE reconsideration case file. The form provides C2C with information necessary for case processing. In addition, C2C directly reports to CMS certain data entered on the form by the MA plan. C2C will report this data as given by the MA plan on the *Reconsideration Background Data Form* and will not attempt to correct errors or omissions.[1]

For Plans utilizing our secure Appeals Portal, an online version of this form will be available for direct completion within the system, eliminating the need to upload a completed copy. Additional information is available in our Portal User Guide, which can be accessed on the C2C's Part C QIC website: https://partcappeals.c2cinc.com.

We recommend that the MA plan type all entries to the *Reconsideration Background Data Form.* If handwritten, the person completing the form should write legibly and print if necessary.

Complete the sections of the *Reconsideration Background Data Form* following the instructions below. If you have questions about any sections, please contact C2C's Plan Liaison prior to completing the form (email provided in the Contact Information section of the Reconsideration Procedures Manual).

[1] For certain compliance data elements (e.g. dates for MA plan appeal activity,) C2C reports to CMS both the dates provided by the MA plan on the Reconsideration Background Data Form and, separately, any discrepancy noted by C2C based upon other case file material. For example, C2C would report a discrepancy to CMS if the date on a notice document did not correspond to the date entered for that notice on the Reconsideration Background Data Form.

The form completion instructions, by Section and data element, are as follows:

1. CASE PRIORITY

Put an X in front of the appropriate Reconsideration Priority

2a. AMOUNT IN CONTROVERSY

The amount in controversy is the actual or estimated cost of the item or service to the appellant (enrollee, estate, or non-contract provider who has executed a Waiver of Liability) if the Medicare Health Plan's adverse determination is upheld at IRE reconsideration.

Enter the amount in whole dollars only.

2b. DATE(S) OF SERVICE IN QUESTION

Enter the dates of service in dispute if the case is a retrospective appeal.

2c. DOES THIS CASE INVOLCE A COST SHARING ISSUE?

Select the appropriate check box if the case involves a cost sharing (i.e. copayment, coinsurance, or deductible) issue.

2d. IS THIS CASE AN AUTO-FORWARD?

Select the appropriate check box if the case has been auto-forwarded due to missed turn-around time.

2e. DOES THE CASE INVOLVE A DENIAL DUE TO MEDICAL NECESSITY?

Select the appropriate check box if the case involves a denial for medical necessity.

3. ENROLLEE DATA

The enrollee information is required even if the reconsideration request was submitted by a non-contracted provider or authorized representative.

- Provide the enrollee's full first and last names.
- Provide the full HIC or MBI number. The Medicare number ("HIC/MBI number") is critical to C2C administration. C2C is unable to initiate the case without the correct HIC or MBI number and therefore will not recognize receipt of the case until the Medicare Health Plan provides the correct HIC or MBI number.
- Provide the last known address even if the enrollee is deceased.

- Indicate whether the enrollee is living or deceased.

- Indicate if the enrollee is enrolled in hospice or was enrolled in hospice on the dates of service at issue.

- C2C will provide determination letters in languages other than English. If the enrollee requires the C2C reconsideration determination notice in a language other than English, notify C2C through the Reconsideration Background Data Form. The language into which the document must be translated must be included in the form.

- C2C will arrange for communication with enrollees in an alternate format if required. If the enrollee requires the C2C correspondence in an alternate format, notify C2C through the Reconsideration Background Data Form. The required alternate format must be included in the form.

4. APPEAL REQUESTOR DATA

- Check one category to identify the requestor - only one category can apply.

    - *Enrollee is Requestor* – use this category unless one of the following categories applies.

    - *Enrollee's treating physician* – use this category only for pre-service and expedited cases. Physicians do not require an Appointment of Representation for these case priorities.

    - *Enrollee's Estate* – An authorized representative of an enrollee's estate may request a reconsideration. The Medicare Health Plan is responsible for determining the validity of the representation documentation. Indicate whether the documentation is provided in the case file.

    - *Non-Contract Provider* – A non-contract provider who is appealing in his or her own interest, and not that of the enrollee. To gain standing as an appellant, the provider must complete a Waiver of Liability document. Indicate whether the Waiver of Liability document is included in the case file.

    - *Representative* – An authorized representative of the enrollee. Please note that a treating physician may support an enrollee appeal without a completed AOR in either an expedited or standard pre-service item, service, or Part B drug appeal. A treating physician must, however, have a completed AOR to represent an enrollee in a retrospective (claim payment) appeal. Indicate whether the appropriate representation document is provided in the file.

- *Surrogate acting in accordance with State Law* – Indicate if the enrollee has a surrogate (e.g. guardianship).

- Enter the following information about the requestor, if not the enrollee: name, telephone number, company/facility/practice name (if applicable), street, city, state, and ZIP.

5. MEDICARE HEALTH PLAN DATA

- Enter the CMS Contract Number (HXXXX or RXXXX) and select the appropriate plan type. Plan types are as follows:

  HMO – Health Maintenance Organization
  MSA – Medicare Savings Account
  HCPP – Health Care Prepayment Plan
  COST – Cost Plan
  PSO – Point of Service Organization
  Local PPO
  Regional PPO
  Demo – CMS Demonstration Plan
  PFFS – Private Fee for Service
  SNP – Special Needs Plan
  PACE – Program for All-inclusive Care for the Elderly
  MMP – Medicare/Medicaid Dual Eligibility Demo Plan
  MMP-NY FIDA – Medicare/Medicaid Fully Integrated Duals Advantage Demo Plan (New York State only)

- Enter the address to which C2C should send correspondence for this particular case (that is, the Case Contact address).

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

- The Medicare Health Plan may designate any authorized individual to act as the liaison with C2C for the submitted case. The Medicare Health Plan may use different authorized individuals for different cases.

- Provide the contact person's name, phone, email, and fax for this case. The C2C reconsideration decision notice will be sent to the fax number provided upon completion. In addition, provide contact information for an alternate person if the contact person is unavailable.

7. MEDICARE HEALTH PLAN ORGANIZATION DETERMINATION

- *Date of Initial authorization request or claim submission* – The Medicare Health Plan should determine the date of request based on the history and facts of the case and

applying CMS regulations (42 CFR §422.566) that define such a request. Enter the date in MM/DD/YY format.

- *Date of Plan's Initial Denial (Organization Determination)* – Enter the date the organization determination was issued or, for NOMNC or inpatient hospital discharge notice, signed by the enrollee. Use MM/DD/YY format.

- *Was an Expedited request made?* – Indicate if the Enrollee or Provider made a request for an Expedited Organization Determination. This question relates to the organization determination, not the subsequent request for an expedited reconsideration.

- *Was the Expedited request granted?* – Check "yes" if the Medicare Health Plan expedited the determination. Check "no" if a request for expedited determination was not granted. Do not answer if no expedited request was made.

- *Did the plan take an extension? (If so, provide notice in file)* – CMS regulations (42 CFR §§422.568 and 422.572) permit the Medicare Health Plan to take up to a 14-calendar day extension in making the organization determination if the extension is taken in the enrollee's interest. The extension applies only to expedited and standard item or service determinations. If the Medicare Health Plan indicates that it took an extension, the Medicare Health Plan is obligated to issue a notice of extension to the enrollee, and this notice should be included in the case file.

8. MEDICARE HEALTH PLAN RECONSIDERATION

The data entered in this section, including blank or missing data, is abstracted by C2C exactly as provided and is then entered into a computer system used for reporting Medicare Health Plan compliance to CMS. This reporting includes calculation of Medicare Health Plan appeal processing timeliness, in comparison to timeliness standards set forth in the Federal regulation.

- *Date of Reconsideration Request* – The Medicare Health Plan should determine the date of request on the basis of the history and facts of the case and applying CMS regulations (42 CFR §422.582) that define such a request. Enter the date in MM/DD/YY format. Plans should enter the date that they received the VALID appeal request (e.g. if the plan received an appeal request from the enrollee's estate on 11/1/14 but did not receive estate documentation until 11/13/14, the plan should enter 11/13/14 as the appeal request date.)

- *Date of MHP Reconsideration Determination* – Enter the date the reconsideration determination was made by the Medicare Health Plan or, if no determination was made, the date the Medicare Health Plan forwarded the case to the IRE. Use MM/DD/YY format.

- *Was an Expedited request made?* – Check "yes" or "no." This response relates to the reconsideration determination, not the prior request for an expedited organization determination.

- *Was the Expedited request granted?* – Check "yes" if the Medicare Health Plan expedited the reconsideration, *whether or not* the enrollee asked for the case to be expedited. Check "no" if a request for expedited reconsideration was not granted.

- *Did the plan take an extension? (If so, please provide notice in file)* – CMS regulations (42 CFR §422.590) permit the Medicare Health Plan to take up to a 14-calendar day extension in making the reconsideration determination if the extension is taken "in the enrollee's interest." The extension applies only to the expedited and standard item or service reconsideration determinations. Check "yes" if the Medicare Health Plan purposefully took such an extension. If "yes" is checked, the Medicare Health Plan is obligated to issue a notice of extension to the enrollee, and this notice should be included in the Medicare Health Plan's case file. Check "no" if the Medicare Health Plan did not purposefully take an extension.

9. PROVIDER IDENTIFICATION DATA

The purpose of this section is to assist C2C in identifying each provider that is referenced in the Medicare Health Plan's case file. Medicare Health Plans should include the provider(s) of denied, or unauthorized, services, as well as any other provider who plays a significant role in the sequence of events surrounding the denial of services or payment. Medicare Health Plans need not identify providers who are merely a part of the member's general utilization history (that is, history unrelated to the denied services).

- Each provider is recorded in this section *only once*. If there are more than four (4) providers, attach a second sheet.

- Complete the "Provider Name" and "Specialty" fields using the space provided on the form for each of these fields. Indicate if medical records were requested, if the records were provided, and if the provider is a contract provider with the plan.

- Indicate if the services at issue were, or are requested to be, performed outside of the service area

- Indicate if the services at issue were, or are requested to be, performed outside of the plan's network

- Indicate if the services at issue were, or are requested to be, performed outside of the enrollee's medical group. If your plan does not utilize medical groups/referral circles, select "N/A."

10. DEFINITION OF DENIED SERVICES OR CLAIMS

The purpose of this section is to provide C2C with a succinct definition of the denied items or services addressed in the case file. Diagnosis and particularly procedure codes will assist C2C to appropriately recognize and address the contested treatment or item.

- *Item/Service in dispute* – provide a brief description of the denied item(s) or service(s)

- *Enrollee's condition related to the Item/Service in dispute* – provide a brief description of the Enrollee's condition related to the item/service in dispute. Please do not provide diagnosis codes in this field.

- *Enrollee's ICD-9/10 diagnosis codes applicable to issues in the case* – provide the diagnosis code(s) on the denied claim or the diagnosis codes from the authorization request

- *HCPCS/CPT Codes representing the items/services in dispute* – provide the appropriate procedure codes from the denied claim or the codes from the authorization request. Do not substitute revenue codes for HCPCS/CPT codes for outpatient hospital services.

11. INDICATE THE DOCUMENTS INCLUDED IN THE FILE

Please complete the check box to identify the specific documentation included in the case file in addition to the reconsideration background data form and the case narrative.

Please note that each case file not submitted for dismissal should include a complete copy of the Evidence of Coverage or Subscriber Agreement. We encourage Medicare Health Plans to submit the Evidence of Coverage or Subscriber Agreement in an electronic format (preferably a searchable .PDF) on a CD or USB drive if mailing the case file to C2C.

III. CASE NARRATIVE

The outline for the required Case Narrative is contained on page 4 of the Reconsideration Background Data Form for reference only. The Medicare Health Plan should supply Case Narrative as a document separate from the Reconsideration Background Data Form. The Case Narrative must be typed. The mandatory sections of the Case Narrative are:

- Case Summary
- Chronology of Care
- Appellant's Arguments for Coverage
- Health Plan Rationale for Denial
- Justification

CASE SUMARY

The purpose of the summary is to orient the C2C reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph or two.

- Provide the enrollee's name, age, sex, specific plan, and information about any supplemental benefits or riders that the enrollee may have.

- Briefly describe the relevant medical history and current condition, including significant changes in status, of the enrollee. Explain how the appellant came to request the service(s) that the Medicare Health Plan denied.

- Provide an exact description of the item(s) or service(s) requested by the appellant and denied by the Medicare Health Plan that are contested in the appeal. Include any relevant technical definition of the denied item/service that facilitates research regarding CMS coverage policies. If the Medicare Health Plan has offered to provide alternative or partial care, and this is important to understand the context of the denial, explain.

- Please note: if the reason for coverage denial is that covered services must be given by a contract provider who is associated with a specific PCP group/network, it is important that you include that information in the case file narrative.

CHRONOLOGY OF CARE

- Define those events that are relevant to an understanding of the enrollee's needs or demands, and how the Medicare Health Plan has attempted to respond. Emphasize meaningful communication, not length. It is not necessary that the chronology repeat appeal processing dates, which are provided on the Reconsideration Background Data Form. The chronology should be presented in a Date/Event format, e.g. "04/15/15 enrollee's medical records receive from PCP."
  Examples of events that a well-written Chronology might contain are:
  - Onset of enrollee's illness or condition (as related to the appeal).
  - Episodes of care, or care seeking behavior, prior to but related to the appeal itself.
  - Consultations by which the enrollee becomes aware of, or requests, the denied service.
  - How the Medicare Health Plan responded to the enrollee's request.

APPELLANT'S ARGUMENTS FOR COVERAGE

- C2C assumes the Medicare Health Plan has provided the appellant with an opportunity to provide input in person, in writing, or by phone. In addition, the

enrollee may have a formal representative or may have obtained letters or other evidence of support from plan, or non-plan providers.

- "Provider support" is deemed to include a provider's prior authorization request, unless there is clear documentation that the provider who filed the request did not support it. A provider might submit a prior authorization request only to satisfy the demand of an enrollee. The Medicare Health Plan would have to provide actual documentation of the provider's lack of endorsement (e.g. a letter from that provider). A general statement, such as "the provider did not support the request," is not sufficient.

- The Medicare Health Plan must provide a faithful summary of each argument advanced by the enrollee and, separately, each argument advanced by a representative or other person supporting the appellant's case. Reference and attach each document in which such an argument is advanced.

- Note that if C2C identifies a valid argument made by an enrollee or supporting person, and that argument is not acknowledged by the Medicare Health Plan, C2C may overturn the Medicare Health Plan denial without seeking clarification (that is, without a Request for Additional Information).

MHP RATIONALE FOR DENIAL

Provide a one or two sentence statement of the Medicare Health Plan's primary reason(s) for denial. Do not list every conceivable reason for the denial, (e.g. "not covered," "not emergent," "not urgent," "not medically necessary," and "not authorized.") List only those reasons applicable to the current case. C2C has found that the following terminology for denial reasons is useful for plans. However, plans may indicate their reasons for denial in any terms the plan chooses.

- *Not Enrolled* – The Medicare Health Plan's records indicate the member was not enrolled on the date(s) that would obligate the Medicare Health Plan to cover the disputed service.

- *Not a Covered Benefit* – The service or item in question is not covered under the member's contract under any normal circumstances (e.g. acupuncture).

- *Exceeded Coverage* – The service is a covered benefit, but the enrollee has exceeded limits set in the subscriber agreement (e.g. covered days, visits, or a dollar maximum).

- *Not an Emergency* – The service is "in area" and the Medicare Health Plan disputes the member's argument that the care met the "prudent layperson" standard for an emergency. This reason is not applicable to out-of-area care that, by definition, need only qualify as "urgent" care (42 CFR §422.113).

- *Not Urgent* – The service was obtained or sought out of the service area and the Medicare Health Plan determines it does not meet the definition of urgent care (42 CFR §422.113).

- *Not Unforeseen* – The service was obtained or sought out of the service area and the Medicare Health Plan determines that it does not meet this qualifying condition for urgent care (42 CFR §422.113).

- *Not Justified by Medicare Health Plan Delay or Withholding of Care* – The service was obtained by the enrollee without authorization or out of network on the argument that the Medicare Health Plan delayed or withheld medically necessary care. The Medicare Health Plan disputes this argument.

- *Not the Treatment Option (or Provider) Approved by Medicare Health Plan* – Applies to a case in which the enrollee seeks (pre-service) or sought (claim denial) a form of treatment that the Medicare Health Plan might recognize as medically appropriate, but the Medicare Health Plan seeks to limit coverage to an alternative appropriate treatment (or provider).

- *Not Skilled Care* – The basis for denial when care is deemed custodial or fails to meet other Medicare qualifying criteria.

- *Not Authorized* - Care not approved in compliance with the Medicare Health Plan's authorization procedures. Usually, this reason is secondary or complementary to a reason above (e.g. "the visit to the Emergency Department was not emergent and was not authorized").

- *Not Medically Necessary* – An item, service, or Part B drug which is covered by the Medicare Health Plan, but which the Medicare Health Plan determines fails to meet the definition of reasonable and necessary (42 CFR §411.15).

- *Not a Medicare Health Plan Provider* – The service sought or obtained by the member was or will be rendered by a provider who is not under contract with the Medicare Health Plan.

JUSTIFICATION

The contents of the Medicare Health Plan's justification will vary based upon its primary reason for denial. However, it is important that the Medicare Health Plan justification not only state the Medicare Health Plan's position, but also offer a specific rebuttal to each argument advanced by the enrollee, representative, or supporting provider.

- *Denials on Issues of Coverage* – If the Medicare Health Plan denies based on coverage, the Medicare Health Plan must justify its denial by review and

interpretation of the applicable Medicare regulations, guidelines, policies, or Medicare Health Plan subscriber agreement. The Medicare Health Plan must include a copy of the applicable Medicare regulation, guideline policy, or provide the exact citation. The citation must be made directly to the applicable Federal policy text (e.g. 42 CFR §XXX.XX). Do not make citations to secondary sources (e.g. CCH. St. Anthony's Medicare Guide, et all).

- *Disputes on Matters of Fact* – In some cases, the appealing party and Medicare Health Plan may disagree on matters of fact (e.g. whether the member called for prior authorization on a given date). If the appellant has raised a factual dispute, the Medicare Health Plan must directly address the issue raised by the appellant and provide any (contrary) evidence that may be available.

- *Denial of Medical Necessity* – If the Medicare Health Plan's denial is based upon a medical judgment (e.g. not emergent, not urgent, not skilled level, not medically necessary), the Medicare Health Plan is required to utilize a physician with appropriate expertise to conduct the medical review (see 42 CFR §422.590). A different physician must be used to make the Medicare Health Plan reconsideration determination.

  The written decisions of these physicians are the most critical components of the Medicare Health Plan's justification, although a nurse or other staff of the Medicare Health Plan may attempt to further document or explain the determinations in the case file. If there is any conflict or difference between the written opinion of the physician's determination and other arguments made in the case file, C2C may defer to the physician's determination.

  The Medicare Health Plan may use a format of its choice for documenting the denial of medical necessity. However, the topics the clinical determinations should address are:

  - Clinical Summary – A statement of the relevant medical history and conditions of the enrollee, including any status changes that relate to the appropriateness of the denied treatment or care.

  - Medicare Health Plan Medical Criteria - Identification and description (copy) of any criteria used by the Medicare Health Plan physicians in their adverse determinations. This could include applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Health Plan internal criteria, purchased proprietary criteria, practice guidelines, recognized medical literature, and technology assessments. Copies of these documents should also be included.

  - Medicare Health Plan Authorized or Recommended Care – An explanation of care or treatment offered or provided by the Medicare Health Plan, if any, in lieu of the (denied) care sought by the enrollee. *The Medicare Health Plan*

must indicate whether this care has actually been offered and authorized, and whether it has been accepted or rejected by the enrollee. In most instances, it is not sufficient for the Medicare Health Plan to indicate that it is "willing" to provide alternative care. The Medicare Health Plan should document that such care has been explained and offered to the enrollee and the enrollee's response.

- *Justification for Denial* – If the Medicare Health Plan has cited and provided Medicare or Medicare Health Plan medical guidelines, the Medicare Health Plan should confirm with the reference to pertinent medical evidence (records) that the patient meets, or fails to meet, all criteria within those guidelines. If there is an argument that the patient has unique needs and should be exempt from the guidelines, that argument should be addressed.

SECTION 2:

RECONSIDERATION BACKGROUND DATA FORM

C2C INNOVATIVE SOLUTIONS, INC. Integrity, Quality & Value – Coast to Coast

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

Medicare Managed Care Reconsideration Case Narrative Outline

Attach to file as a document separate from the Background Data Form.

Please note, if the reason for coverage denial is that covered services must be given by a contracted provider who is associated with a specific PCP group/network it is important that you include that information in the case file narrative.

1.	**Case Summary:** Please make sure to include the following: Enrollee name, age, sex, specific plan (i.e., Value Plan vs Deluxe Plan) and information about any supplemental riders that the enrollee may have, in addition to a description of the item/service in dispute.
2.	**Chronology of Care:** This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates of service as appropriate).
3.	**Appellant's Arguments for Coverage**
4.	**MHP Rationale for Denial**
5.	**Justification:** Include citations to rules, regulations, etc. upon which the plan denied coverage.

SECTION 3:

INSTRUCTIONS FOR DISMISSAL CASE FILE DATA FORM FOLLOWING IRE REQEUST FOR DISMISSAL CASE FILE AND DISMISSAL CASE NARRATIVE

INSTRUCTIONS FOR COMPLETION OF: MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM AND DISMISSAL CASE NARRATIVE

I. GENERAL ORGANIZATION OF SUBMITTED DISMISSAL CASE FILE MATERIAL

Consult the C2C *Medicare Health Plan Reconsideration Process Manual* for general instructions on dismissal case file development. The instructions that follow apply to completion of the mandatory:

- Medicare Managed Care Dismissal Case File Data Form
- Case Narrative

II. INSTRUCTIONS FOR COMPLETION OF MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM

The Medicare Health Plan must submit a completed Medicare Managed Care Dismissal Case File Data Form with each new dismissal case file request from the IRE. The form provides C2C with information necessary for review of the Medicare Health Plan's dismissal action. In addition, C2C directly reports to CMS certain data entered on the form by the MA plan.

For Plans utilizing our secure Appeals Portal, an online version of this form will be available for direct completion within the system, eliminating the need to upload a completed copy. Additional information is available in our Portal User Guide, which can be accessed at C2C's Part C QIC website: https://partcappeals.c2cinc.com.

We recommend that the Medicare Health Plan type all entries into the Medicare Managed Care Dismissal Case File Data Form. If handwritten, the person completing the form should write legibly and print if necessary.

Complete the sections of the Medicare Managed Care Dismissal Case File Data Form, following the instructions below. Do not leave a required section or data element blank if you are uncertain how to code it. If you have questions about any sections, please contact C2C's Plan Liaison prior to completing the form (email provided in the Contact Information section of the Reconsideration Procedures Manual).

The form completion instructions, by Section and data element, are as follows:

C2C CASE NUMBER:

Enter the case number that was provided on the Dismissal Case File Request fax.

1. CASE PRIORITY

Put an X in front of the appropriate priority.

2. DATE(S) OF SERVICE IN QUESTION

Enter the dates of service in dispute if the case is a dismissal review of a standard claim.

3. DISMISSAL REASON

Indicate the reason that the Medicare Health Plan dismissed the appeal request.

4a. ENROLLEE DATA

The enrollee information is required even if the reconsideration is submitted by a non-contract provider or authorized representative.

- Provide the enrollee's full first and last name.
- The Medicare number ("HIC/MBI Number") is critical to C2C's administration. C2C is unable to initiate the case without the correct HIC or MBI number and therefore will not recognize receipt of the case file until the Health Plan provides the correct HIC or MBI number.
- Provide the last known address even if the enrollee is deceased.
- C2C will provide determination letters in languages other than English. If the enrollee requires the C2C determination notice in a language other than English, notify C2C through the Medicare Managed Care Dismissal Case File Data Form. The language into which the document must be translated must be included in the form.
- C2C will communicate with enrollees in an alternate format if required. If the enrollee requires the C2C correspondence in an alternate format, notify C2C through the Dismissal Case File Data Form. The required alternate format must be included in the form.

4b. REQUESTOR DATA

- Check one category to identify the requestor; only one category can apply.
  - *Enrollee is Requestor* – Use this category unless one of the following categories applies.

- *Enrollee's treating physician* – Use this category only for pre-service and expedited cases. Physicians do not require an Appointment of Representation for these case priorities.

- *Enrollee's Estate* – An authorized representative of an enrollee's estate may request a reconsideration. The Medicare Health Plan is responsible for determining the validity of the representation documentation. Indicate whether the documentation is provided in the case file.

- *Non-Contract Provider* – A non-contract provider who is appealing in his or her own interest, and not that of the enrollee. To gain standing as an appellant, the provider must complete a Waiver of Liability document. Indicate whether the Waiver of Liability document is included in the case file.

- *Representative* – An authorized representative of the enrollee. Please note that a treating physician may support an enrollee appeal without a completed AOR in either an expedited or standard pre-service, item, service, or Part B drug appeal. A treating physician must, however, have a completed AOR to represent an enrollee in a retrospective (claim payment) appeal. Indicate whether the appropriate representation documentation is provided in the file.

- *Surrogate acting in accordance with State Law* – Indicate if the enrollee has a surrogate (e.g. guardianship).

- Enter the following information about the requestor, if not the enrollee: name, telephone number, company/facility/practice name (if applicable), street, city, state, and ZIP.

5. MEDICARE HEALTH PLAN (MHP) DATA

- Enter the CMS Contract umber (HXXXX or RXXXX)

- Enter the address and fax number to which C2C should send correspondence for this particular case (that is, the Case Contact address).

6. MHP CONTACT PERSON FOR THIS DISMISSAL REVIEW

- The Medicare Health Plan may designate any authorized individual to act as the liaison with C2C for the submitted case. The Medicare Health Plan may use different authorized individuals for different cases.

- Enter the name, phone number, email address, and fax numbers for the person acting as the point of contact for this particular case. The dismissal decision notice will be sent to the fax number provided upon completion. In addition, provide contact information for an alternative person if the contact person is unavailable.

7. **INDICATE THE DOCUMENTS INCLUDED IN THE DISMISSAL FILE**

Please complete the check box included to identify the documentation included in the case file in addition to the dismissal background form and the dismissal case narrative. Please note that each dismissal case file submitted should include a copy of the *Notice of Dismissal* issued by the plan, as well as the other supporting documentation listed.

DISMISSAL CASE FILE NARRATIVE

The outline for the required Dismissal Case File Narrative is contained on page 2 of the Medicare Managed Care Dismissal Case File Data Form for reference only.

The Medicare Health Plan should supply a Dismissal Case File Narrative as a document separate from the Medicare Managed Care Dismissal Case File Data Form. The Dismissal Case File Narrative must be typed.

The mandatory sections of the Dismissal Case File Narrative are:

- Dismissal Case Summary
- Dismissal Chronology
- Health Plan Dismissal Rationale
- Justification

1. DISMISSAL CASE SUMMARY

Briefly describe the Medicare Health Plan's dismissal case. Explain how the appellant came to request the service(s) that the Medicare Health Plan denied. The purpose of the summary is to orient the C2C reviewers and condense the information provided in the following sections. The summary should not exceed a paragraph.

2. DISMISSAL CHRONOLOGY

Define those events that are relevant to the plan's dismissal of the appellant's request. This chronology should include dates of initial authorization request/denial, date of plan organization determination, date of the appellant's invalid appeal request, dates of attempts to secure representative documentation, Waiver of Liability, or good cause, as applicable, and the date that the plan issued its Notice of Dismissal. The Chronology should be presented in a Date/Event format.

3. MHP DISMISSAL RATIONALE

Provide a one or two sentence statement of the Medicare Health Plan's reason or dismissing the appellant's request.

4. JUSTIFICATION

The contents of the Medicare Health Plan's justification will vary based upon its reason for dismissal. Plans should cite the rule relied upon to dismiss the appellant's request. The plan should also address any denials of good cause or rejections of submitted representative documentation.

SECTION 4:

DISMISSAL CASE FILE DATA FORM

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 # (REQUIIRED): ______________________ 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

DISMISSAL CASE FILE NARRATIVE

Attach to file as a document separate from the Dismissal Case File Data Form.

1.	**Dismissal Case Summary:**
2.	**Dismissal Chronology:** This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates of service as appropriate.
3.	**MHP Dismissal Rationale**
4.	**Justification:** Include citations to rules, regulations, etc. upon which the plan denied coverage.

SECTION 5

PLAN RESPONSE TO IRE REQUEST FOR ADDITIONAL DOCUMENTATION TRANSMITTAL COVER SHEET

PLAN RESPONSE TO IRE REQUEST FOR ADDITIONAL DOCUMENTATION

TRANSMITTAL COVER SHEET

For use to submit a response to an IRE request for additional documentation from the Plan.

To ensure the additional documentation gets associated with the correct appeal case at the IRE, **please include this transmittal cover sheet with all responses provided**. If mailing or using courier services, please refer to the Contract Information in our Reconsiderations Manual for address information.

Portal Submission: Please Complete this Form Online in our Secure Portal and upload the related documentation.
Fax Submission: Pease send the completed form and related documentation to C2C at:
Expedited Appeals: 904-539-4075
Standard Part B Drug Appeal: 904-539-4076
All Other Appeal Types: 904-539-4078

C2C Reconsideration Case Number: ___________________________

Response Related to an Expedited Case?: YES_______ NO________

Enrollee Name: ____

Enrollee HIC Number: ____

Identify Additional Documentation Submitted	Check if submitted

SECTION 6

STATEMENT OF COMPLIANCE FORM-IRE DECISION

C2C INNOVATIVE SOLUTIONS, INC.
Integrity, Quality & Value – Coast to Coast

NOTICE TO COMPLY WITH
IRE/Part C QIC RECONSIDERATION DETERMINATION

C2C Innovative Solutions, Inc.

Medicare Part C QIC

P.O. Box 1949
Jacksonville, FL
32231-0053

Part C QIC Appeals Portal Accessible at:
https://partcappeals.c2cinc.com

Fax Number for Attestations:

904-539-4096

Plan Liaison Telephone Number:

866-439-0863

Federal regulations require your organization to effectuate the attached IRE Part C Reconsideration Determination within a specific time period.

These time periods are:

Appeal Priority	*Effectuation Due (from receipt of Decision)*
Expedited Part B Drug	Authorize or Provide service within 24 hours*
Expedited Item or Service	Authorize or Provide service within 72 hours*
Standard Item or Service (Pre-service)	Authorize service within 72 hours **or** Provide service within 14 calendar days*
Standard Claim (Retrospective)	Pay for service within 30 calendar days (Check number required for proof of payment)

* Or as expeditiously as the enrollee's health condition requires

An IRE Part C Reconsideration Determination is final and binding. The determination may only be revised through a Reopening Determination. A request for reopening does not extend your organization's compliance date. Compliance requirements are only relieved if your organization receives a favorable Reopening Determination notice from C2C before the compliance due date.

Your organization has no appeal right to an Administrative Law Judge.

Please provide written notice of compliance to C2C through our secure Appeals Portal, the fax number listed in the banner, or by mail within fourteen (14) calendar days from the date the payment, authorization, or provision of services and/or supplies is effectuated.

To ensure proper handling, please use the attached form when notifying C2C of compliance.

INNOVATIVE SOLUTIONS, INC.
Integrity, Quality & Value – Coast to Coast

IRE/PART C QIC DECISION
PLAN STATEMENT OF COMPLIANCE FORM

Enrollee Name (First initial, last name)		
Health Plan Contact		
C2C Reconsideration Case #		
Health Plan Name		
Health Plan Contract # (H# or R#)		
Authorization # and Date Required for pre-service and expedited cases	#	Date
Check # or EFT# and Date Required for retrospective cases	#	Date

Important information:

- C2C cannot waive compliance with a Reconsideration Determination.
- If you cannot comply with the Reconsideration Determination, you must notify your Account Manager at the CMS Regional Office.
- Compliance notice for Standard Claim (retrospective) cases that do not contain a check number or EFT number will be rejected and referred to the CMS Regional Office Account Manager for review.

Please return this form to us via our secure appeals portal, fax, or mail:

Portal: https://partcappeals.c2cinc.com/

Fax: 904-539-4096

Mail: C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – Effectuation Compliance
P.O. Box 1949
Jacksonville, FL 32231-0053

SECTION 7

REOPENING REQUEST FORM

C2C INNOVATIVE SOLUTIONS, INC. Integrity, Quality & Value – Coast to Coast

IRE/Part C QIC: PLAN REOPENING REQUEST FORM

Please return this form to us via mail:
C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C - Reopening
P.O. Box 1949
Jacksonville, FL 32231-0053

Enrollee Name: ______________________________

C2C Reconsideration Case Number: ______________________________

Dates of Service: ______________________________

Medicare Health Plan Name: ______________________________

Medicare Health Plan Contact: ______________________________

Contact Title: ______________________________

Street Address: ______________________________

Mail Stop: ______________________________

City/State/Zip: ______________________________

Telephone Number: ______________________________ Ext: __________

Fax Number: ______________________________ Date of Request: __________

Basis of Reopening Request:

Error on the face of the evidence

New and material evidence

Fraud

Explain briefly:

SECTION 8

STATEMENT OF COMPLIANCE FORM – ALJ DECISION

NOTICE TO COMPLY WITH ADMINISTRATIVE LAW JUDGE DETERMINATION

C2C Innovative Solutions, Inc.

Medicare Part C QIC

P.O. Box 1949
Jacksonville, FL
32231-0053

Part C QIC Appeals Portal Accessible at: https://www.c2cinc.com/QIC-Part-C

Fax Number for Attestations:

904-539-4096

Plan Liaison Telephone Number:

866-439-0863

Federal regulations require your organization to effectuate the attached Administrative Law Judge Determination within the specific period stated below.

Appeal Priority	*Effectuation Due (from receipt of Decision)*
Expedited Part B Drug	Authorize or provide service as expeditiously as the enrollee's health condition requires but no later than 24 hours. *
Expedited or Standard Item or Service (Pre-service)	Authorize or provide service as expeditiously as the enrollee's health condition requires but no later than 60 calendar days. *
Standard Claim (Retrospective)	Pay for service no later than 60 calendar days. *

*If the MA organization makes a valid request for Medicare Appeals Council (MAC) review, the MA organization may await the outcome of the review before it pays for, authorizes, or provides the service under dispute.

To ensure proper reporting, the MA Organization should notify C2C that it has requested an appeal to the Medicare Appeals Council (MAC) at the time the MAC review request is made.

To ensure proper handling, please use the attached form to notify C2C that you have either requested MAC review or that you have complied with effectuation.

C2C INNOVATIVE SOLUTIONS, INC. Integrity, Quality & Value – Coast to Coast

ADMINISTRATIVE LAW JUDGE DECISION PLAN STATEMENT OF COMPLIANCE FORM

Enrollee Name (First initial, last name)		
Health Plan Contact		
C2C Reconsideration Case Number #		
ALJ Case #		
Health Plan Name		
Health Plan Contract # (H# or R#)		
Request has been made for MAC review.	Date:	
Authorization # and Date Required for pre-service and expedited cases	#	Date
Check # or EFT# and Date Required for retrospective cases	#	Date

Important information:

- Send completed form no later than 14 days after the effectuation date.
- If you cannot comply with the ALJ Determination, you must notify your Account Manager at the CMS Regional Office.
- Compliance notice for Standard Claim (retrospective) cases that do not contain a check number or EFT number will be rejected and referred to CMS Regional Office Account Manager for review.

Please return this form to us via our secure appeals portal, fax, or mail:

Portal: https://www.c2cinc.com/QIC-Part-C

Fax: 904-539-4096

Mail: C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – Effectuation Compliance
P.O. Box 1949
Jacksonville, FL 32231-0053

SECTION 9

STATEMENT OF COMPLIANCE FORM – MEDICARE APPEALS COUNCIL (MAC) DECISION

C2C INNOVATIVE SOLUTIONS, INC. Integrity, Quality & Value – Coast to Coast

NOTICE TO COMPLY WITH
MEDICARE APPEALS COUNCIL DETERMINATION

C2C Innovative Solutions, Inc.

Medicare Part C QIC

P.O. Box 1949
Jacksonville, FL
32231-0053

Part C QIC Appeals Portal Accessible at:
https://www.c2cinc.com/QIC-Part-C

Fax Number for Attestations:

904-539-4096

Plan Liaison Telephone Number:

866-439-0863

Federal regulations require your organization to effectuate the attached Medicare Appeals Council Determination within the specific period stated below.

Appeal Priority	*Effectuation Due (from receipt of Decision)*
Expedited Part B Drug	Authorize or provide service as expeditiously as the enrollee's health condition requires but no later than 24 hours. *
Expedited or Standard Item or Service (Pre-service)	Authorize or provide service as expeditiously as the enrollee's health condition requires but no later than 60 calendar days. *
Standard Claim (Retrospective)	Pay for service no later than 60 calendar days. *

To ensure proper handling, please use the attached form to notify C2C that you have either requested MAC review or that you have complied with effectuation.

C2C INNOVATIVE SOLUTIONS, INC.
Integrity, Quality & Value – Coast to Coast

MEDICARE APPEALS COUNCIL (MAC) DECISION
PLAN STATEMENT OF COMPLIANCE FORM

Enrollee Name (First initial, last name)		
Health Plan Contact		
C2C Reconsideration Case #		
MAC Case #		
Health Plan Name		
Health Plan Contract # (H# or R#)		
Authorization # and Date Required for pre-service and expedited cases	#	Date
Check # or EFT# and Date Required for retrospective cases	#	Date

Important information:

- Send completed form no later than 14 days after the effectuation date.
- If you cannot comply with the MAC Determination, you must notify your Account Manager at the CMS Regional Office.
- Compliance notice for Standard Claim (retrospective) cases that do not contain a check number or EFT number will be rejected and referred to CMS Regional Office Account Manager for review.

Please return this form to us via our secure appeals portal, fax, or mail:

Portal: https://www.c2cinc.com/QIC-Part-C

Fax: 904-539-4096

Mail: C2C Innovative Solutions, Inc. - QIC Part C
Attn: QIC Part C – Effectuation Compliance
P.O. Box 1949
Jacksonville, FL 32231-0053

SECTION 10

NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEETS FOR RECONSIDERATIONS AND IRE REVIEW OF PLAN DISMISSAL CASE FILES SUBMITTED TO IRE OUTSIDE OF QIC APPEALS PORTAL

PLAN SUBMISSION OF NEW RECONSIDERATION CASE FILE TRANSMITTAL COVER SHEET

This transmittal sheet is required whenever a Plan submits a case and corresponding case file (including the case file narrative and all supporting documentation) to C2C outside of the QIC Appeals Portal.

To ensure proper handling, the Plan must include this transmittal sheet for each case submitted to the IRE via mail or overnight courier.

The C2C mailing address and courier address, by appeal type, is denoted in the Contact Information section of the Reconsiderations Procedures Manual.

Does this case involve an Expedited Appeal? YES NO

Member Name: ____

Member HIC/MBI Number: ____

Document	Check if submitted
Reconsideration Background Data Form	
Case File Narrative	
Representative Documentation or WOL (if applicable)	
Organization Determination Notice with Appeal Rights	
Notice of Appeals Status/Closure Letter	
Appeal Letter (or phone records if an expedited request was made)	
Evidence of Coverage (EOC): Please send in a PDF format on a CD or Thumb Drive.	
Medicare Health Plan Decision Making Criteria	
Legible Medical Records (if applicable)	
Other Documentation (if applicable)	

C2C INNOVATIVE SOLUTIONS, INC.
Integrity, Quality & Value – Coast to Coast

PLAN SUBMISSION OF NEW DISMISSAL CASE FILE (FOR IRE REVIEW OF A PLAN DISMISSAL) TRANSMITTAL COVER SHEET

This transmittal sheet is required whenever a Plan submits a dismissal case and corresponding case file (including the dismissal case file narrative and all supporting documentation) to C2C outside of the QIC Appeals Portal.

To ensure proper handling, the Plan must include this transmittal sheet for each dismissal case file submitted to the IRE via mail or overnight courier.

The C2C mailing address and courier address, for submission of dismissal case files, is denoted in the Contact Information section of the Reconsiderations Procedures Manual.

Does this dismissal case involve an Expedited Appeal? YES NO

Member Name: ____

Member HIC/MBI Number: ____

Document	Check if submitted
Dismissal Case File Data Form	
Dismissal Case File Narrative	
Correspondence of Attempts to Get Representative Documentation or WOL (when applicable)	
Appeal Letter (or phone records if an expedited request was made)	
Documentation regarding the Plan's assessment of good cause (if applicable)	
Other Documentation (if applicable)	

SECTION 11

PLAN SUBMISSION OF ADDITIONAL INFORMATION AUTHORIZING COVERAGE OR PAYMENT FOR AN ITEM, SERVICE, OR PART B DRUG SUBSEQUENT TO THE PLAN SUBMISSION OF THE CASE AND CASE FILE TO THE IRE FOR PROCESSING OF THE IRE RECONSIDERATION

PLAN SUBMISSION OF ADDITIONAL INFORMATION AUTHORIZING COVERAGE OR PAYMENT FOR AN ITEM, SERVICE, OR PART B DRUG SUBSEQUENT TO THE PLAN SUBMISSION OF THE CASE AND CASE FILE TO THEIRE FOR PROCESSING OF THE IRE RECONSIDERATION

This form is to be used by the Medicare Health Plan to provide the IRE with additional information for consideration when the Plan has authorized or made payment for the item, service, or Part B drug in dispute **after** the case file has already been submitted to C2C for processing. Plans should complete the information below and submit it to C2C as soon as the approval decision has been made to help prevent the issuance of a substantive appeal decision by C2C. Please attach any documentation supporting the Plan's approval. Examples include authorization notices, screen prints reflecting approval issuance, or documentation showing that the claim was paid (e.g., EFT confirmation, check number).

Upon validation of the information provided, if C2C has not already adjudicated the case, C2C will issue a favorable decision to the party indicating that the item, service, or Part B drug was authorized or paid for on the specified date and that no issues remain in dispute.

Please Complete this Form Online in our Secure Portal or Fax the Completed Form to C2C at:
Expedited Appeals: 904-539-4075
Standard Part B Drug Appeal: 904-539-4076
All Other Appeal Types: 904-539-4078

Enrollee First & Last Name: ____

C2C Reconsideration Case Number: __________________________

QIC Portal Confirmation Number (if applicable): ___________________________________

Dates(s) of Service or Item/Service at Appeal: _____________________________________

Medicare Health Plan Name: ____

Medicare Health Plan Contract Number: ____

Medicare Health Plan Contact Name: _____________________________________

Contact Email Address:____

Contact Fax Number: ____

Telephone Number: ____ Ext: _______

Date of Authorization or Payment for Item, Service or Part B Drug: ____________

Explain briefly the Plan actions taken. Clearly identify the specific item, service, or Part B drug the Plan has authorized or paid for and attach documentation supporting the authorization or payment for the date(s) of service at issue.

SECTION 12

MEDICARE PART C QIC RECONSIDERATIONS KEY PLAN ORGANIZATION CONTACT FORM

Medicare Part C QIC Reconsiderations
Key Plan Organization Contact Form

This contact form is for Medicare Advantage (MA) Organizations, Medicare Cost Plans, Health Care Prepayment Plans (HCPPs) and Program of All-Inclusive Care for the Elderly (PACE) Organizations providing Medicare Part C items, services or Medicare Part B drugs.

Each plan must complete the form below to designate one or two key organizational contact(s) for general appeal-related communications and escalated case-specific concerns. **Plans are strongly encouraged to complete this form directly online via the C2C Part C QIC Website:** https://www.c2cinc.com/QIC-Part-C.

Note: For routine case-specific activities, C2C Innovative Solutions, Inc. will communicate with the contact identified in the Part C Reconsideration Background Form for the respective appeal.

If not completed online, please email the completed form to:

PartC-Plan_Liaison@c2cinc.com

PLAN CONTACT INFORMATION	
Contract Number	
Contract Name	
Contract Type	
Mailing Address	
Mail Stop/Suite Number	
City	
State	
Zip Code	
Primary Contact Name	
Primary Contract Phone #, ext.	
Primary Contact Email	
Alternate Contact Name	
Alternate Contact Phone #, ext.	
Alternate Contact Email	
Effective Date of Change (if applicable)	

Submitted by: ______________________________ Date: ___________