



QIC IRE Part C Appeals Portal User Guide

Version 1.0

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Introduction

The C2C QIC IRE Part C Appeals Portal is the secure electronic interface for the Medicare Part C Qualified Independent Contractor (QIC). C2C is the independent review entity (IRE) contracted by the Centers for Medicare & Medicaid Services (CMS) to conduct Level 2 Reconsiderations. Starting on May 1, 2026, C2C will be responsible for receiving and conducting new reconsiderations of adverse organization determinations and adverse reconsiderations made by Medicare Advantage (MA) Organizations, Medicare Cost Plans, Health Care Prepayment Plans (HCPPs) and Program of All-Inclusive Care for the Elderly (PACE) Organizations, in addition to any CMS-approved Medicare managed care demonstrations.

The purpose of the portal is to provide Medicare Health Plans (MHP) with a centralized, secure, and efficient method to submit case files and manage correspondence related to disputed healthcare services or payments. Beginning with the initial May 1, 2026, the Portal will be available exclusively to Medicare Health Plans and demonstrations. Near-term expansion will include access for PACE Organizations, with longer-term plans to extend availability to providers, enrollees, and their representatives.

As Portal updates and enhancements occur, C2C will update this User Guide accordingly and post related announcements on its Part C QIC web page.

Registration for the Portal

Users can register for the portal at the following URL. <https://partcportal.c2cinc.com/>. Upon visiting the link, users will be directed to the main sign on page for accessing the portal. Click the “Register” link to be redirected to the registration page.



Username

Password

[Forgot your password?](#)

LOG IN

[Register](#)

On the registration page, users will be asked for their organization and contact information. User’s email address will constitute the username to log in to the portal application.



Organization type*

Organization name*

Contract number*

First name*

Last name*

Job title*

Middle name (optional)

Address*

Address line 2 (optional)

City*

State*

Zip code*

Work phone*

Cell phone*

Request for information fax*

Decision letter fax*

Email*

Password*

Password confirmation*

REGISTER

Upon registering, users will be sent a confirmation email letting them know that their request is being reviewed by the C2C Portal Team. Once approved, users will receive a notification via email with a URL to activate their account. The link must be visited before login attempts can be made.

Logging into the Portal

Users must authenticate through the portal's secure gateway using username and password.



Username

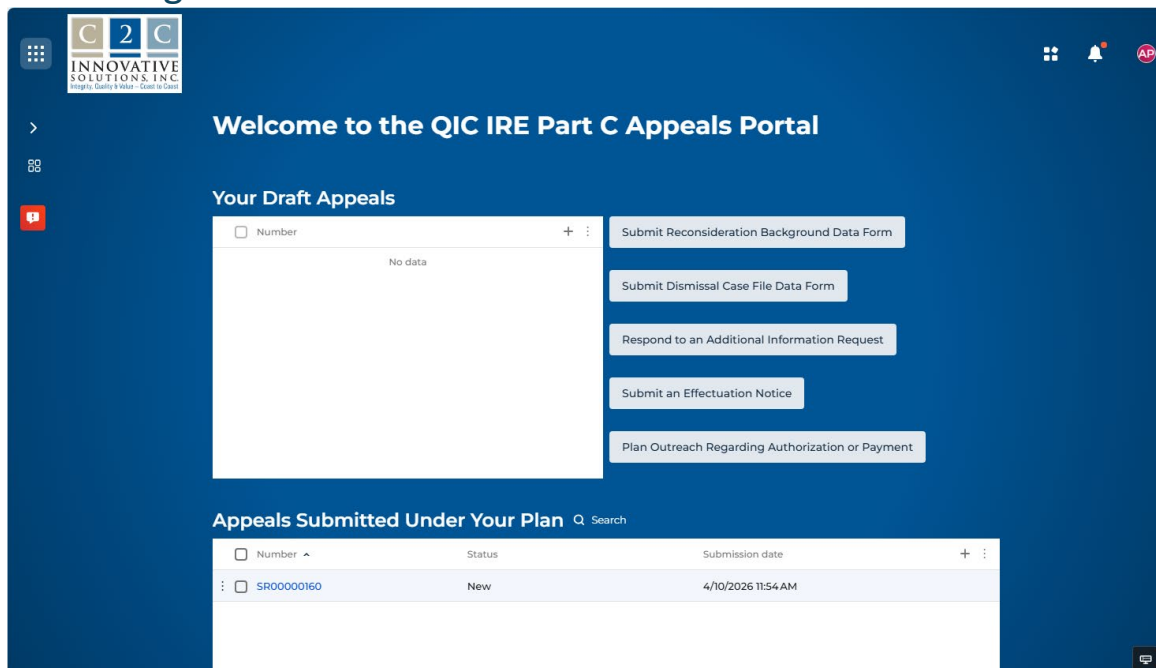
Password

[Forgot your password?](#)

Navigating the Portal

Navigation is divided into three sections: buttons to initiate new actions, your draft appeals table, and appeals submitted under your plan table.

Home Page



The screenshot shows the home page of the QIC IRE Part C Appeals Portal. The header includes the C2C logo and the text "Welcome to the QIC IRE Part C Appeals Portal". Below the header, there are two main sections:

- Your Draft Appeals:** A table with a "Number" column and a "Status" column. The table is currently empty, showing "No data". To the right of the table are five buttons: "Submit Reconsideration Background Data Form", "Submit Dismissal Case File Data Form", "Respond to an Additional Information Request", "Submit an Effectuation Notice", and "Plan Outreach Regarding Authorization or Payment".
- Appeals Submitted Under Your Plan:** A table with a "Number" column, a "Status" column, and a "Submission date" column. The table contains one row:

Number	Status	Submission date
SR00000160	New	4/10/2026 11:54 AM

Table - Your Draft Appeals

When a user partially completes a Reconsideration Background Data Form, the incomplete form is listed in the “Your Draft Appeals” table.

Table - Appeals Submitted Under Your Plan

Submitted appeals are listed in the “Appeals Submitted Under Your Plan” table. In this table, a user is able to see all active appeals with C2C that have been submitted by them or other users belonging to the same Medicare Health Plan. This table allows the user to search for a specific appeal.

Button - Submit Reconsideration Background Data Form

This module allows users to submit a new case and appeal file, including the ability to complete the Medicare Managed Care Reconsideration Background Form in the Portal.

Button - Submit Dismissal Case File Data Form

This module is used when a Plan has dismissed a Level 1 Plan reconsideration request. Upon receipt of a dismissal case file request from the QIC, the Plan can use this module to complete the *Dismissal Case File Data Form* in the Portal and upload the related dismissal case narrative and other supporting documentation.

Button - Respond to an Additional Information Request

This module allows users to submit new documents for a previously submit Case. For example, when the QIC requests additional information or documentation from a Plan, the Plan can use this module to upload the requested materials.

Button - Submit an Effectuation Notice

If, on reconsideration, C2C fully or partially overturns a plan's determination, the plan must authorize, provide, or pay for the item, service, or Part B Drug in dispute within the regulatory timeframes as denoted in the Part C QIC Notice to Comply issued to the Plan. This section of the Portal allows plans to submit proof of timely compliance.

Button - Plan Outreach Regarding Authorization or Payment

This function is used for communication between the Plan and C2C regarding the financial status of an item, service, or Part B Drug. If the Plan has authorized an item, service, or Part B Drug, or issued payment after submitting the case and case file to the QIC, the Plan may use this module to notify the QIC of that authorization or payment.

If the QIC determines the information and documentation provided are credible and compelling, the QIC will, in accordance with section 6.6.4 of the Reconsideration Procedures Manual, issue a favorable decision to the enrollee or other party, based on the information submitted by the Plan.

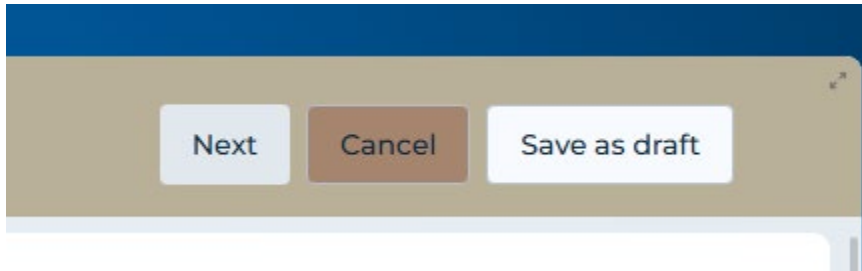
Submit Reconsideration Background Data Form

To forward an adverse organization determination or adverse reconsideration to the QIC for review, click "Submit Reconsideration Background Data Form" from the portal home page. This module allows Plans to complete an online version of the Reconsideration Background Data Form. This form is organized into multiple pages and sections for ease of completion.

Throughout the submission form, use the following buttons to navigate and manage your progress:

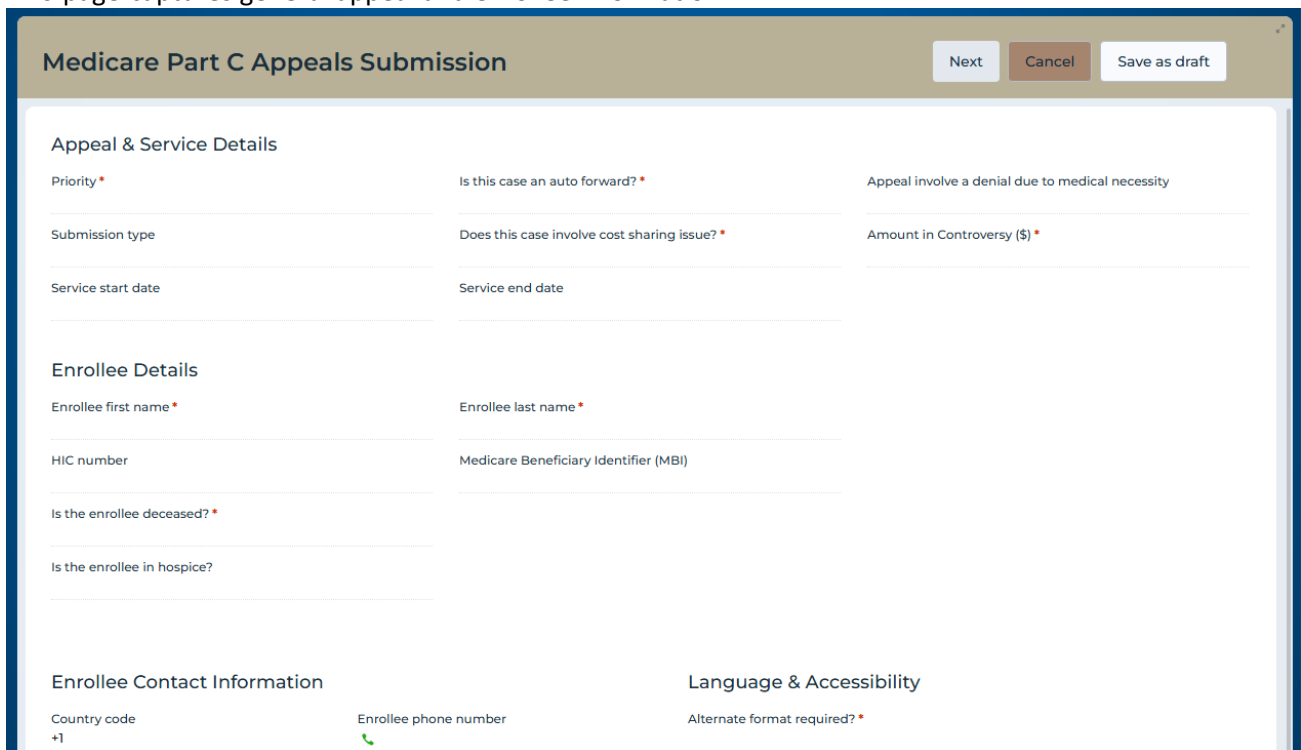
- **Next** — proceed to the next page

- Complete all required fields (marked with *) before advancing to the next page. The Portal will prevent you from advancing and display an error message if you omit any required information.
- **Back** — return to the previous page
- **Cancel** — exits the form without saving
- **Save as Draft** — saves your current progress. A popup will display a temporary ID (SRxxxxxxx) which you can use later to locate your draft. Your draft will appear under Your Draft Appeals table on the portal home page.



Page 1 — Appeal & Enrollee Information

This page captures general appeal and enrollee information.



Medicare Part C Appeals Submission Next Cancel Save as draft

Appeal & Service Details

Priority *	Is this case an auto forward? *	Appeal involve a denial due to medical necessity
Submission type	Does this case involve cost sharing issue? *	Amount in Controversy (\$) *
Service start date	Service end date	

Enrollee Details

Enrollee first name *	Enrollee last name *
HIC number	Medicare Beneficiary Identifier (MBI)
Is the enrollee deceased? *	
Is the enrollee in hospice?	

Enrollee Contact Information **Language & Accessibility**

Country code +1	Enrollee phone number	Alternate format required? *
--------------------	-----------------------	------------------------------

Appeal & Service Details

This section captures general case information:

- Priority
 - If Priority is Standard claim (Reimbursement) then Service Start date and Service end date are required

- Is this case an auto forward?
- Amount in Controversy (\$)
- Does this case involve cost sharing issues?

Enrollee Details

This section captures the enrollee information:

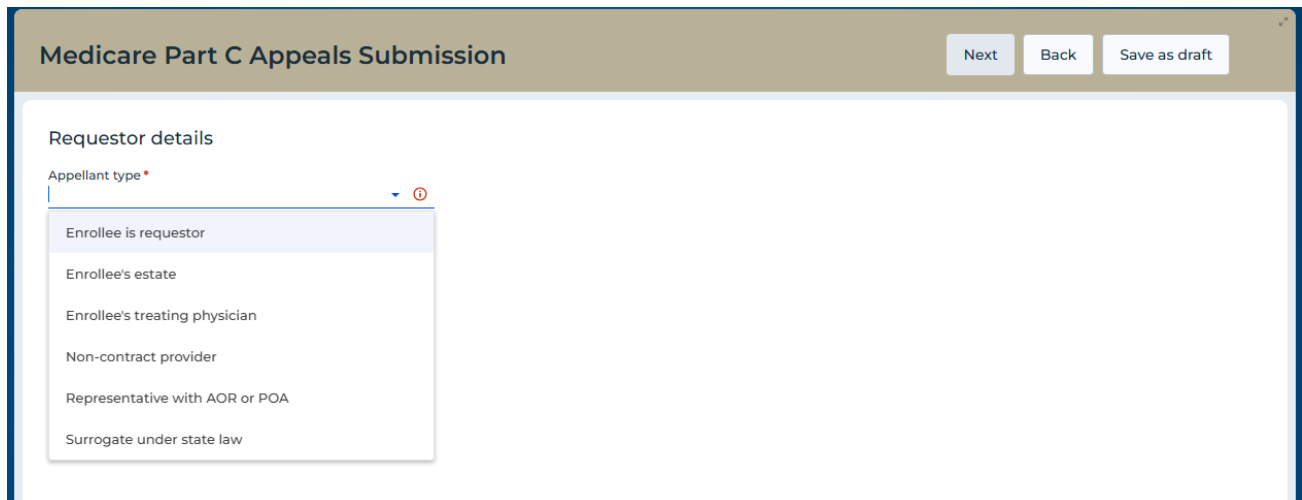
- Enrollee first name
- Enrollee last name
- HIC Number or Medicare Beneficiary Identifier
 - At least one is required.
- Is the Enrollee Deceased?
 - If Enrollee is deceased: An additional required field, Enrollee Date of Death, will display.
- If Enrollee is in Hospice: An additional required field, Enrollee Hospice Election Date, will display. Note that the Election Form must be included with your submission. It can be uploaded when you reach the File Upload page.
- Enrollee Contact Information
 - Enrollee phone number
 - Enrollee street address
 - Enrollee city
 - Enrollee state
 - Enrollee zip
- Language & Accessibility
 - Alternate Format Required?
 - If Alternate Format Required = Yes: An additional required field, Alternate Format Type, will display. Select the appropriate format from the dropdown list.
 - Is Final Determination Notice in English?
 - Is Final Determination Notice in English = No: An additional required field, Beneficiary language preference, will display. Select the appropriate format from the dropdown list.

Page 2 — Requestor Details

This page captures information about the person that requested the appeal.

Requestor Details

Select the Appellant Type is a required field.



Medicare Part C Appeals Submission Next Back Save as draft

Requestor details

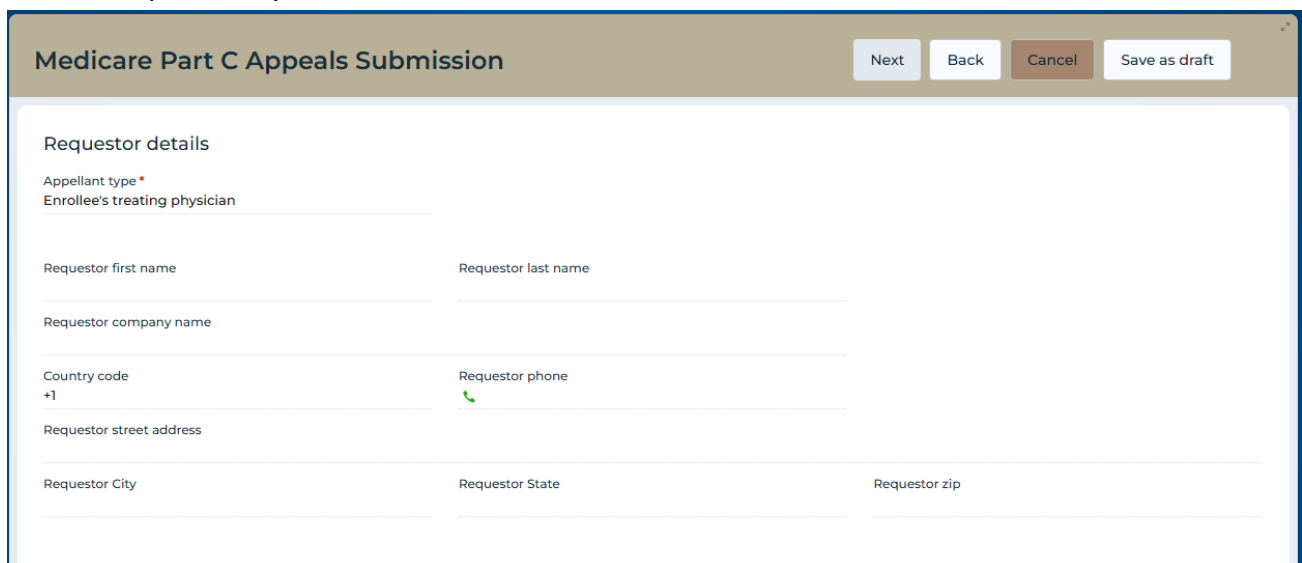
Appellant type *

- Enrollee is requestor
- Enrollee's estate
- Enrollee's treating physician
- Non-contract provider
- Representative with AOR or POA
- Surrogate under state law

If Appellant Type = Enrollee is requestor: The Portal will use the enrollee information captured in the prior page, no additional requestor information is required. Proceed to the next page.

Otherwise, the requestor information is captured on this page

- Requestor first name
- Requestor last name
- Requestor Company name
- Country code
- Requestor Phone
- Requestor street address
- Requestor city
- Requestor state
- Requestor zip



Medicare Part C Appeals Submission Next Back Cancel Save as draft

Requestor details

Appellant type *
Enrollee's treating physician

Requestor first name Requestor last name

Requestor company name

Country code +1 Requestor phone

Requestor street address

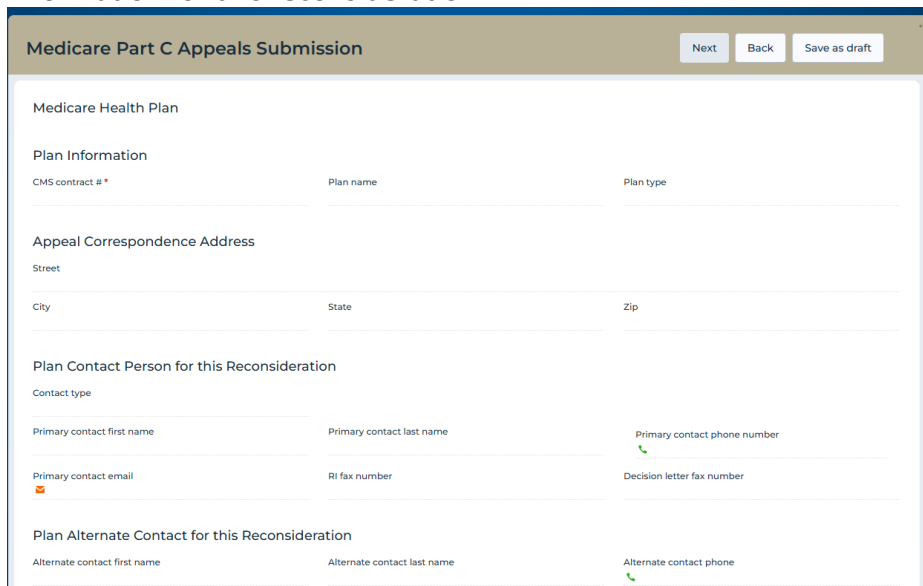
Requestor City Requestor State Requestor zip

Depending on the Appellant Type selection, additional fields will display:

- If Appellant Type = Enrollee's Estate, then Estate Docs in File? will display. Select Yes if the estate documentation is included in your case file upload.
- If Appellant Type = Non-Contract Provider, then Waiver of Liability in File? will display. Select Yes if the waiver of liability document is included in your case file upload.
- If Appellant Type = Representative with AOR or POA, then AOR or POA in File? will display. Select Yes if the AOR or POA document is included in your case file upload.

Page 3 — Medicare Health Plan

This page captures information about the Medicare Health Plan and the specific contact information for this reconsideration.



The screenshot shows a web form titled "Medicare Part C Appeals Submission". At the top right, there are three buttons: "Next", "Back", and "Save as draft". The form is divided into several sections:

- Medicare Health Plan**: This section contains a "Plan Information" table with columns for "CMS contract #", "Plan name", and "Plan type".
- Appeal Correspondence Address**: This section contains fields for "Street", "City", "State", and "Zip".
- Plan Contact Person for this Reconsideration**: This section contains a "Contact type" dropdown and several input fields: "Primary contact first name", "Primary contact last name", "Primary contact phone number", "Primary contact email", "RI fax number", and "Decision letter fax number".
- Plan Alternate Contact for this Reconsideration**: This section contains input fields for "Alternate contact first name", "Alternate contact last name", and "Alternate contact phone".

Plan Information

Once the required field, CMS Contract #, is selected from the drop down list, the Plan Name and Plan Type are automatically populated and are read-only.

Appeal Correspondence Address

Street, City, State and ZIP are also automatically populated based on the CMS Contract # selection and are read-only.

Plan Contact Person for this Reconsideration

Select the Contact Type to automatically populate default contact information.

- If Contact Type = Use My Contact Details: First Name, Last Name, Phone, and Email will be auto-populated with your account's contact information.
- If Contact Type = Use Default Plan Contact: First Name, Last Name, Phone, and Email will be auto-populated with the plan's default contact information.
- If Contact Type = Other: The following fields must be entered:
 - Primary Contact First Name
 - Primary Contact Last Name
 - Primary Contact Phone Number
 - Primary Contact Email
 - RI Fax Number

- Decision Letter Fax Number

Plan Alternate Contact for this Reconsideration

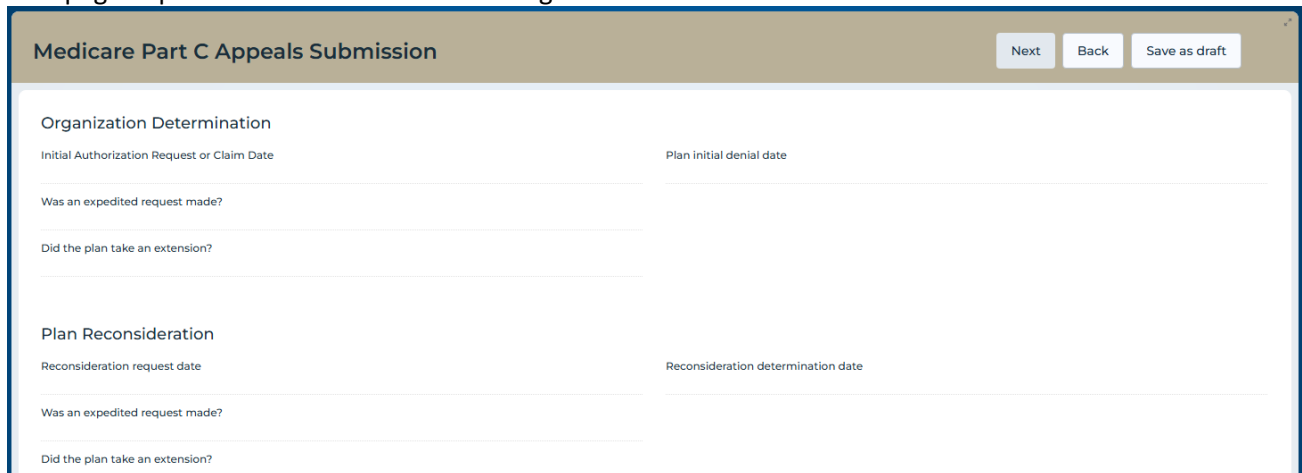
Enter alternate contact information for this reconsideration

First Name

- Last Name
- Phone Number

Page 4 — Appeal Decision Details

This page captures information about the organization determination and Plan reconsideration



The screenshot shows a web form titled "Medicare Part C Appeals Submission". At the top right, there are three buttons: "Next", "Back", and "Save as draft". The form is divided into two main sections: "Organization Determination" and "Plan Reconsideration".

Organization Determination

- Initial Authorization Request or Claim Date
- Plan initial denial date
- Was an expedited request made?
- Did the plan take an extension?

Plan Reconsideration

- Reconsideration request date
- Reconsideration determination date
- Was an expedited request made?
- Did the plan take an extension?

Organization Determination

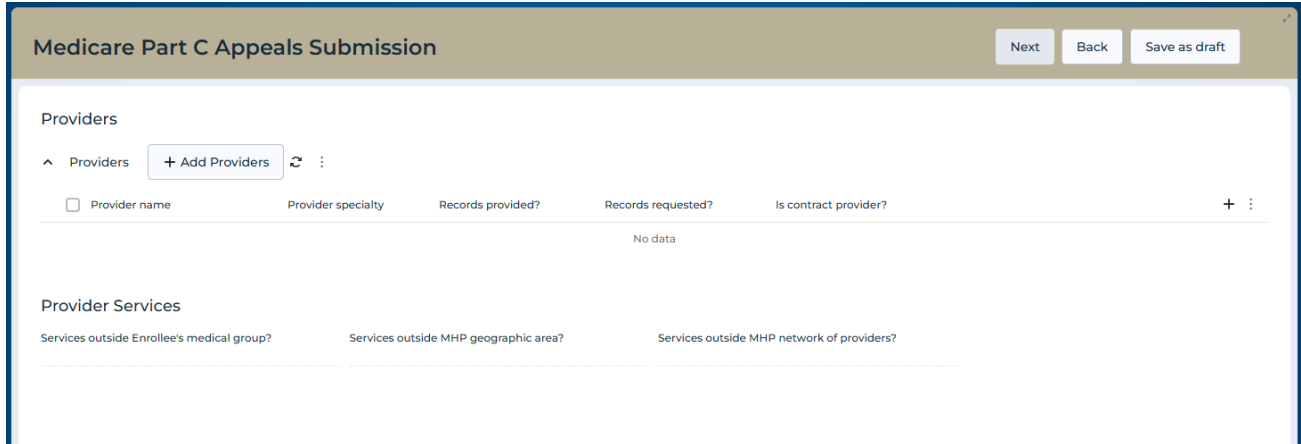
- Initial Authorization Request or Claim Date
- Plan Initial Denial Date
- Was an Expedited Request Made?
 - If Expedited Request Made = Yes: An additional field Was the Expedited Request Granted? is displayed. Select Yes or No.
- Did the Plan Take an Extension?
 - If Plan Took an Extension = Yes: Please include the extension notice when you reach the File Upload page.

Plan Reconsideration

- Reconsideration Request Date
- Reconsideration Determination Date
- Was an Expedited Request Made?
 - If Expedited Request Made = Yes: An additional field Was the Expedited Request Granted? will display. Select Yes or No.
- Did the Plan Take an Extension?
 - If Plan Took an Extension = Yes: Please include the reconsideration extension notice when you reach the File Upload page.

Page 5 — Providers

This page captures information about the providers associated with the appeal and logistical information about the services.



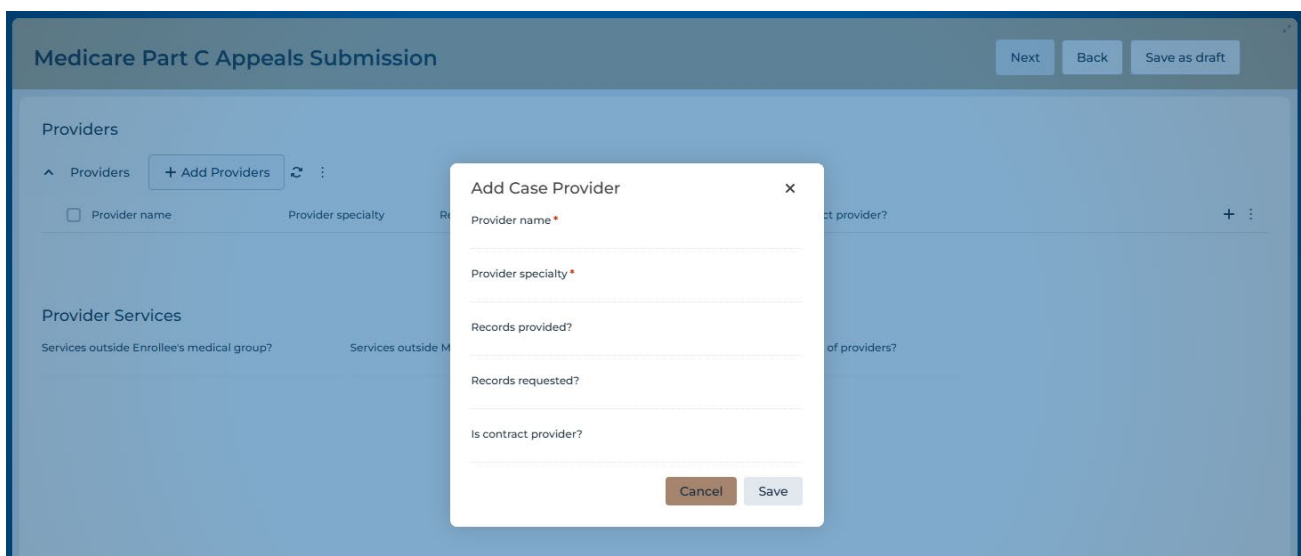
This page captures information about the providers associated with the appeal and logistical information about the services.

Providers

This section captures the providers associated with this appeal. At least one provider must be added.

Click the + Add Providers button to add a provider. A popup window will appear with the following fields:

- Provider Name
- Provider Specialty
- If Provider Specialty = Other: An additional field Provider Specialty (Other) will appear. Enter the provider's specialty manually.
- Records provided?
- Records requested?
- Is a contract provider?



Click Save to save the provider's record. The provider will appear in the providers list on the page.

Note: You may add multiple providers by clicking + Add Providers again and repeating the process.

Providers Services

This section captures logistical information about the services

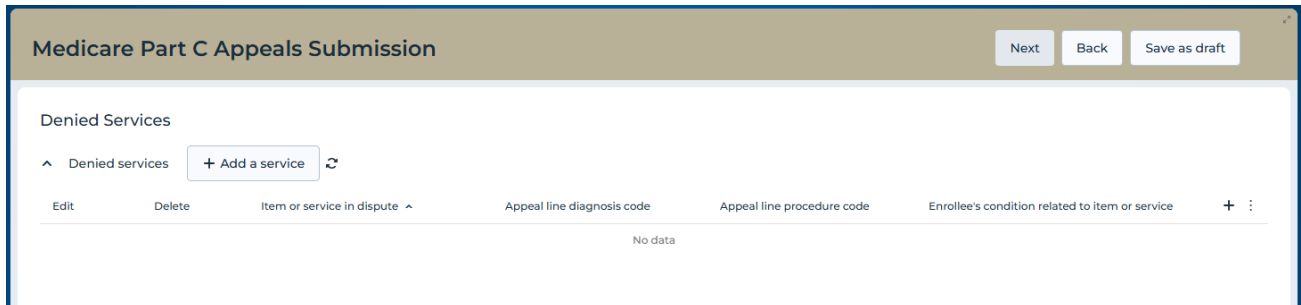
- Services Outside Enrollee's Medical Group?
- Services Outside MHP Geographic Area?
- Services Outside MHP Network of Providers?

Page 6 — Denied Services

This page captures information about the denied services being disputed.

Denied Services

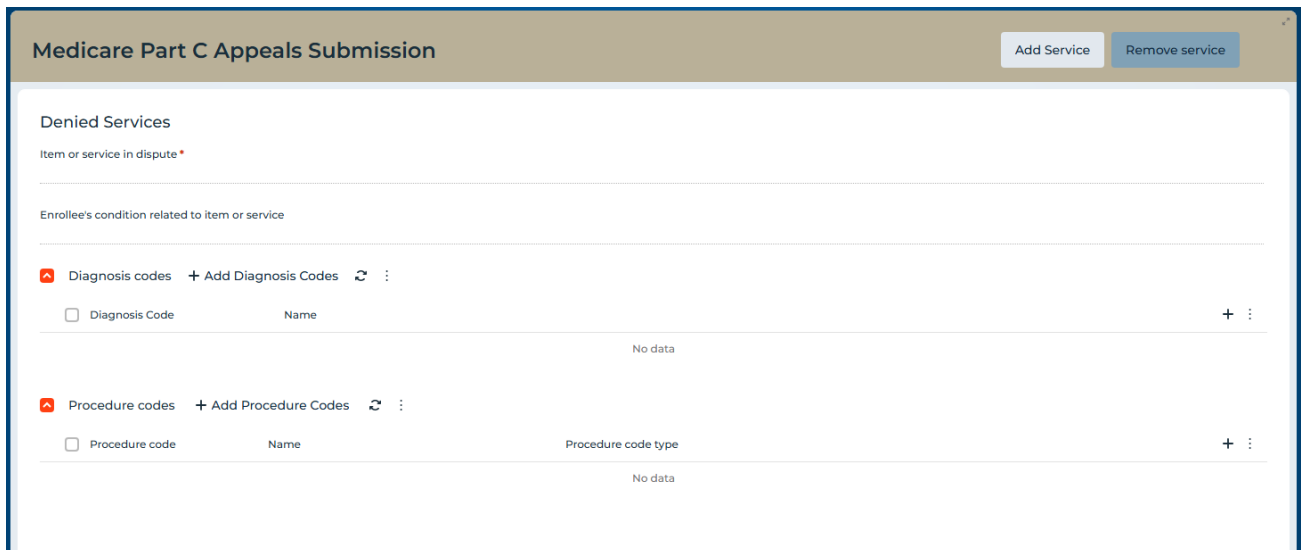
At least one denied service must be added.



The screenshot shows the 'Medicare Part C Appeals Submission' form. At the top right are buttons for 'Next', 'Back', and 'Save as draft'. The 'Denied Services' section has a '+ Add a service' button and a table with the following columns: 'Edit', 'Delete', 'Item or service in dispute', 'Appeal line diagnosis code', 'Appeal line procedure code', and 'Enrollee's condition related to item or service'. The table currently contains 'No data'.

Click the + Add a Service button to add a denied service. This will open the Denied Services page with the following fields:

- Item or Service in Dispute
- Enrollee's Condition Related to Item or Service



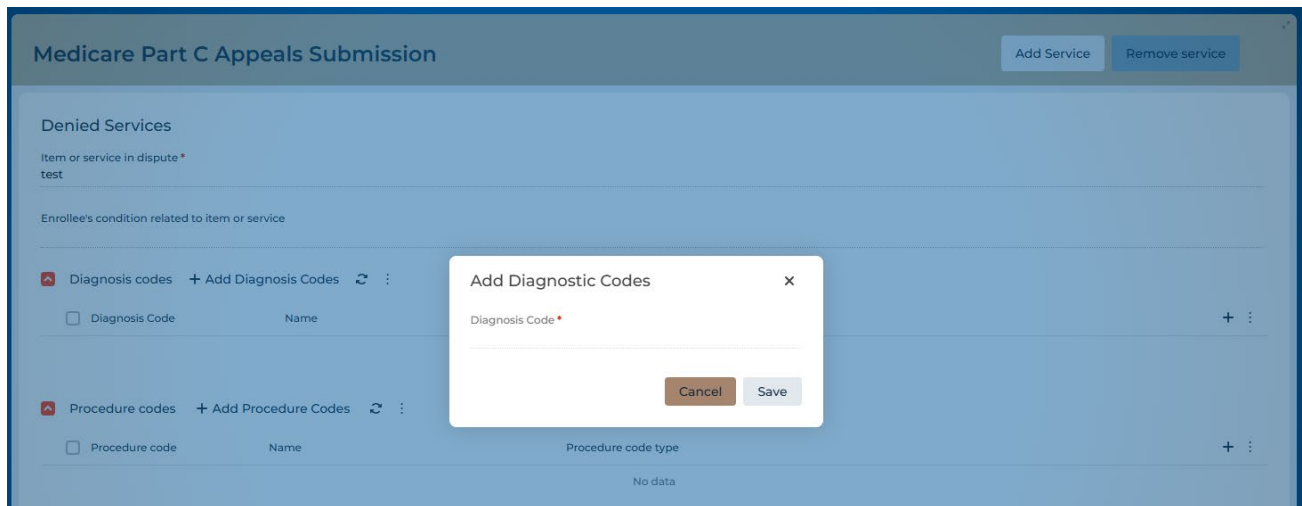
The screenshot shows the 'Medicare Part C Appeals Submission' form with the 'Add Service' and 'Remove service' buttons at the top right. The 'Denied Services' section includes input fields for 'Item or service in dispute' and 'Enrollee's condition related to item or service'. Below these are sections for 'Diagnosis codes' and 'Procedure codes', each with a '+ Add' button and a table. The 'Diagnosis codes' table has columns for 'Diagnosis Code' and 'Name'. The 'Procedure codes' table has columns for 'Procedure code', 'Name', and 'Procedure code type'. Both tables currently show 'No data'.

Diagnosis Codes

To add diagnosis codes associated with this service:

- Click + Add Diagnosis Codes in the Diagnosis Codes list
- A popup will appear — select the applicable diagnosis code from the dropdown

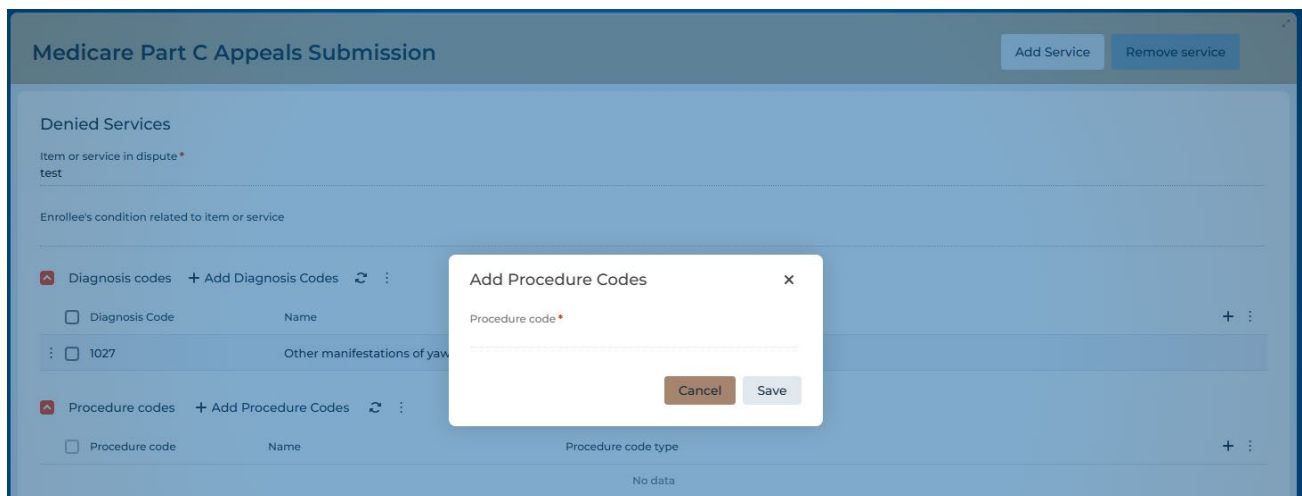
- Click Save to add the code to the list
- Note: You may add multiple diagnosis codes by repeating this process.



Procedure Codes

To add procedure codes associated with this service:

- Click + Add Procedure Codes in the Procedure Codes list
- A popup will appear — select the applicable procedure code from the dropdown
- Click Save to add the code to the list
- Note: You may add multiple procedure codes by repeating this process.



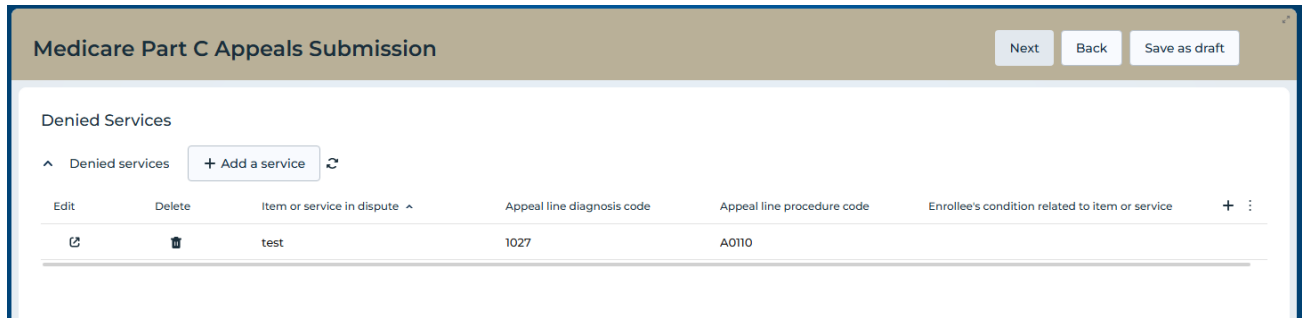
Once all information has been entered, click Add Service to save the denied service and return to the main Denied Services page.

If users wish to delete the entered data, they can click on Remove Service button, so it's not added to the appeal.

Note: You may add multiple denied services by clicking + Add a Service again and repeating the process.

Once you submit a service, it brings you to the main Denied Services page. There are two buttons next

to each service that enable you to edit or delete the entry as needed.



Medicare Part C Appeals Submission [Next] [Back] [Save as draft]

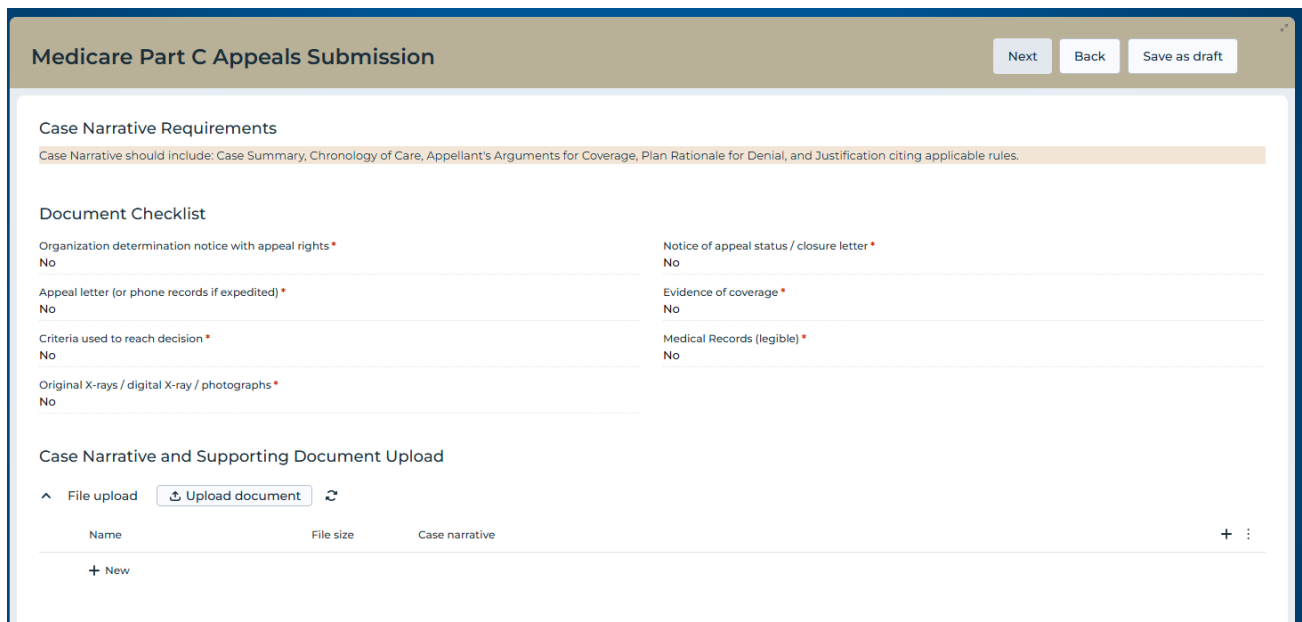
Denied Services

Denied services [Add a service] [Refresh]

Edit	Delete	Item or service in dispute	Appeal line diagnosis code	Appeal line procedure code	Enrollee's condition related to item or service	+	:
[Refresh]	[Trash]	test	1027	A0110			

Page 7 — File Upload

This page enables you to upload the case file documentation.



Medicare Part C Appeals Submission [Next] [Back] [Save as draft]

Case Narrative Requirements

Case Narrative should include: Case Summary, Chronology of Care, Appellant's Arguments for Coverage, Plan Rationale for Denial, and Justification citing applicable rules.

Document Checklist

Organization determination notice with appeal rights *	No	Notice of appeal status / closure letter *	No
Appeal letter (or phone records if expedited) *	No	Evidence of coverage *	No
Criteria used to reach decision *	No	Medical Records (legible) *	No
Original X-rays / digital X-ray / photographs *	No		

Case Narrative and Supporting Document Upload

File upload [Upload document] [Refresh]

Name	File size	Case narrative	+	:
+ New				

Case Narrative Requirements

Before uploading, please ensure your Case Narrative document includes the following:

Case Narrative should include: Case Summary, Chronology of Care, Appellant's Arguments for Coverage, Plan Rationale for Denial, and Justification citing applicable rules.

Document Checklist

Indicate whether each of the following documents is (Yes), or is not (No), included in your case file.

- Organization Determination Notice with Appeal Rights
- Notice of Appeal Status / Closure Letter
- Appeal Letter (or Phone Records if Expedited)
- Evidence of Coverage
- Criteria Used to Reach Decision
- Medical Records (Legible)
- Original X-Rays / Digital X-Ray / Photographs
- **Note:** For each item you select Yes, ensure the corresponding document is included in the

upload section below.

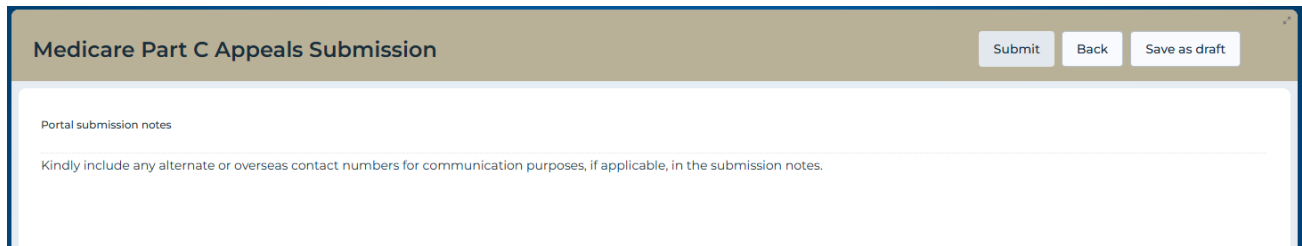
Case Narrative and Supporting Document Upload

To upload documents:

- Click the Upload Document button
- Select your file — supported formats are PDF, DOC, DOCX
- For the Case Narrative document, check the Case Narrative checkbox to identify it as the case narrative
- Click Save All to save your edits
- Note: A Case Narrative document is required to submit this form. Ensure you have checked the Case Narrative checkbox on the appropriate file before proceeding.
- Note: You may upload multiple documents by clicking Upload Document again and repeating the process.
- Note: There will be a separate dialog box that will pop-up if the file naming convention is not met. File names should not contain special characters, and the maximum number of characters is 100.

Page 8 — Submission Notes

Submission Notes

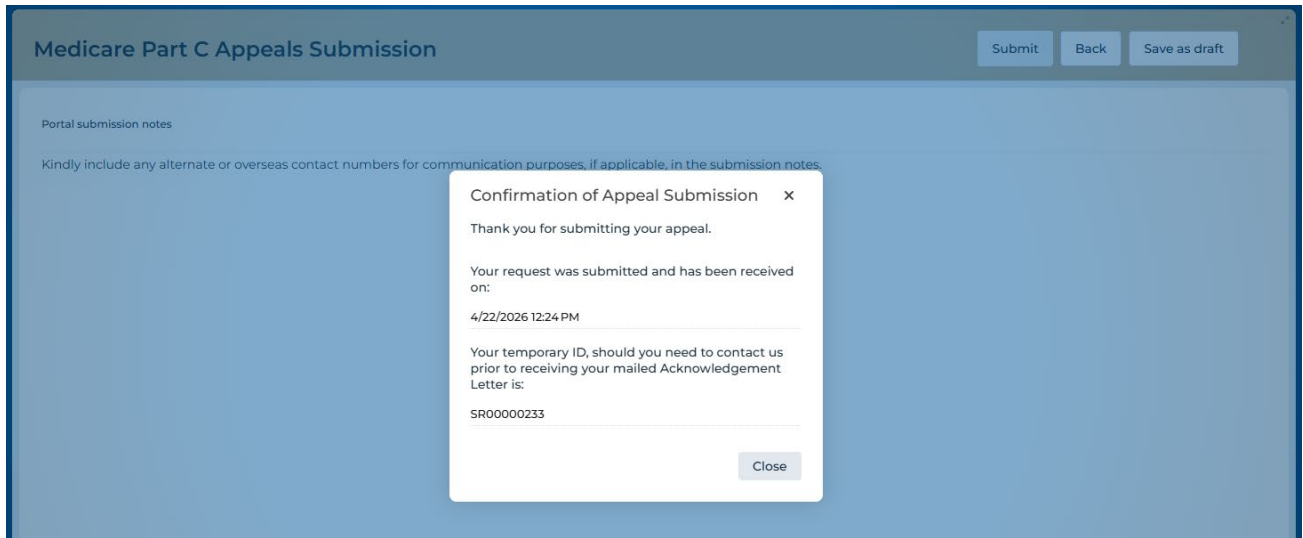


The screenshot shows a web form titled "Medicare Part C Appeals Submission". At the top right, there are three buttons: "Submit", "Back", and "Save as draft". Below the title bar, the section is labeled "Portal submission notes". A text area contains the instruction: "Kindly include any alternate or overseas contact numbers for communication purposes, if applicable, in the submission notes."

Enter any additional notes regarding this submission, or any additional contact information or overseas phone numbers etc. Once all pages are complete, click Submit to submit your appeal.

Confirmation

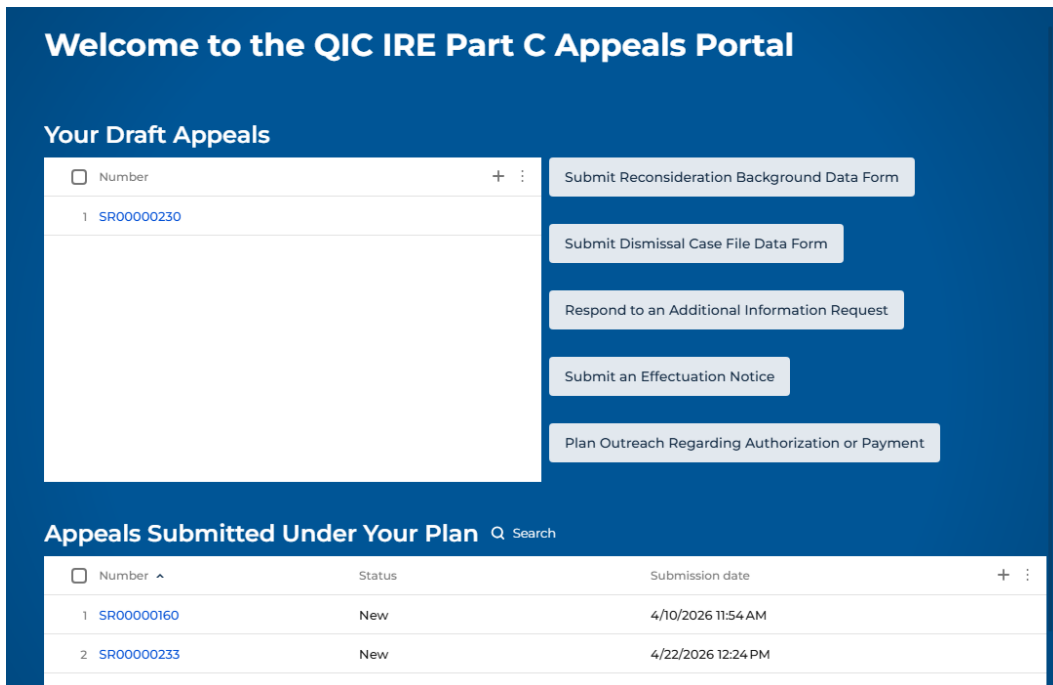
Upon successful submission, a confirmation popup will appear with the submission date and time and a temporary ID for reference. Click Close to dismiss the confirmation window.



You will be returned to the portal home page. Your submitted appeal will appear in the Appeals Submitted Under Your Plan list, where you can view and track all appeals submitted under your plan.

Portal Home Page Status

Users can view appeals submitted under the current plan in the list view “Appeals Submitted Under Your Plan” on the appeal portal landing page. Users can then click on the temporary tracking number and be brought to the appeal page where they can track appeal status and take actions against the appeal directly.



Submit a Dismissal Case File Data Form

The Dismissal Case File workflow is utilized when a Plan receives a request for the case file of a dismissal and dismissal case file narrative from the Part C QIC. Plans using this module can complete the Dismissal Case File Data Form (as identified in the Appendix of the Reconsideration Procedures Manual) online through the Portal.

Plan Dismissal Reasons

The user must categorize the administrative failure that led to the dismissal. Common reasons include:

- **Untimely Filing:** The request was received after the 60-day filing window without "good cause" for the delay.
- **Missing Waiver of Liability (WOL):** A non-contracted provider failed to submit a signed WOL, which is a requirement for them to have standing in a payment appeal.
- **Invalid/Missing Representative:** The Appointment of Representative (AOR) form was missing, expired, or lacked required signatures.
- **Withdrawal of Request:** The enrollee or representative submitted a written request to rescind the appeal.

Dismissal Case File Narrative Requirements

A standard medical case narrative is not sufficient for a dismissal. The portal requires a specific narrative document containing:

- **Dismissal Case Summary:** A high-level overview of the administrative issue.
- **Dismissal Chronology:** A detailed timeline (e.g., date of original denial, date the appeal was received, and dates of any "Request for Information" sent by the plan).
- **MHP Dismissal Rationale:** A clear explanation of the plan's logic in dismissing the case.
- **Justification:** Citations to the specific Medicare Managed Care Manual chapters or CMS regulations that support the dismissal.

Dismissal Case File Checklist

The documentation requirements for a dismissal are distinct from a standard appeal. The user must provide:

- **The Original Appeal Request:** The letter, form, or transcript of the request that initiated the appeal.
- **The Notice of Dismissal of Appeal Request:** A copy of the formal notice the plan mailed to the enrollee informing them of the dismissal.
- **Proof of Outreach:** Documentation showing the plan attempted to help the requestor fix the administrative deficiency (e.g., a "Cure Letter" sent to obtain a missing AOR).
- **Organization Determination:** The original denial notice (the "Level 0" decision) that was being challenged.

Submission Process

- **Data Entry:** The user enters the specific dismissal dates and reasons into the portal fields.
- **Uploads:** The user uploads the Dismissal Case File Narrative and the items identified in the Dismissal Checklist as a consolidated PDF or organized set of files.

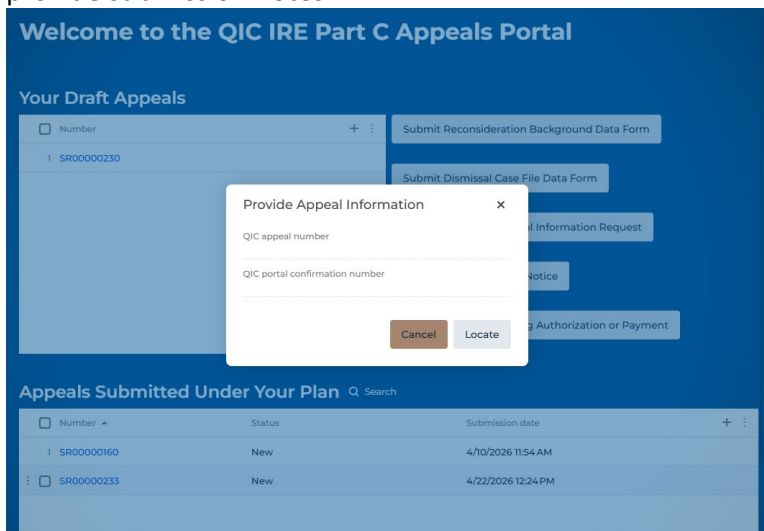
- **C2C Action:** C2C will review the record. If they find the dismissal was improper, they will remand the case back to the plan for a full Level 1 clinical review. If they agree with the plan, the dismissal is affirmed.

The File upload page has following sections

- **Dismissal Reason**
 - Users need to select the Dismissal Reason here. If “Other” is selected as a reason then another field will appear to allow users to provide details.
- **Dismissal Case File Narrative**
 - Provides the information related to case narrative file that is required to be uploaded with the request.
- **Dismissal Case file Checklist**
 - Users need to provide additional information as a checklist of all the documents here
- **Dismissal Case File Narrative and Documents Upload**
 - In this section users can upload the documents using the “Upload document” button.

Respond to an Additional Information Request / Upload Additional Documents

There are two ways users can upload additional documents against an existing appeal. One from the button “Respond to an additional information request” on the portal homepage and other, via clicking on the appeal in the list view under “Appeals Submitted Under Your Plan” label on the home page. With the latter option, users will be directed to the respective appeal page, and they can upload additional documents by clicking “Submit additional documents” button on the upper right corner of the screen. In both ways, the users will be prompted to provide the details for the appeal on a mini-page window that opens. Either of the appeal number or the temporary ID can be provided here. If it’s an existing appeal, then the users will be directed to the page where they can upload additional documents and provide submission notes.



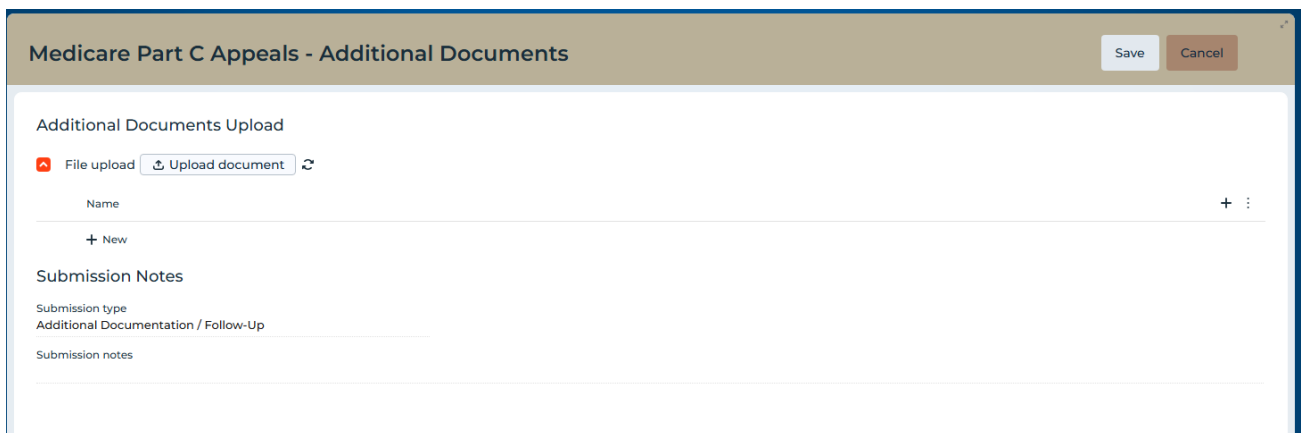
If the appeal is not found, the users will see an error displayed on the screen stating that Appeal Not found.



If it's an existing appeal, then the following page opens with two sections, one for file upload and a second for providing submission notes.

Additional Documents Upload

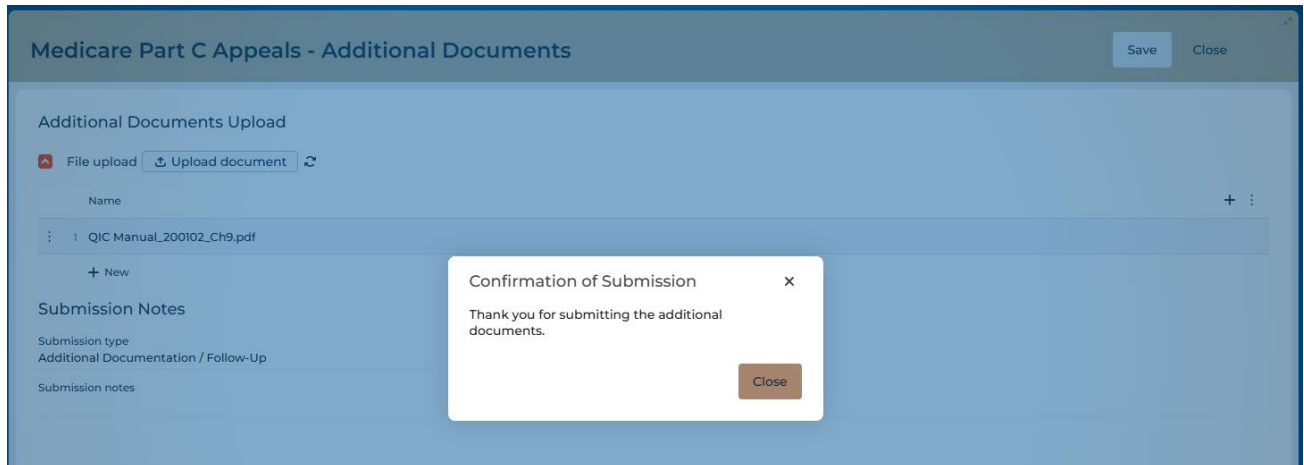
Users can upload additional documents by clicking the "Upload document" button. Upon successful upload, the document will appear in the list-view on the page under the Additional Documents Upload section.



Submission Notes

After the additional documents section the users can provide submission notes.

Users can then proceed to submit the request by clicking Save, and a confirmation message will be displayed on the screen.



Submitting an Effectuation Notice

There are two ways users can submit Effectuation notice. One from the button “Submit an effectuation notice” on the portal homepage and other, via clicking on the appeal in the list view under “Appeals Submitted Under Your Plan” label on the home page. With the latter option, users will be directed to the respective appeal page, and they can upload additional documents by clicking “Submit Effectuation Notice” button on the upper right corner of the screen.

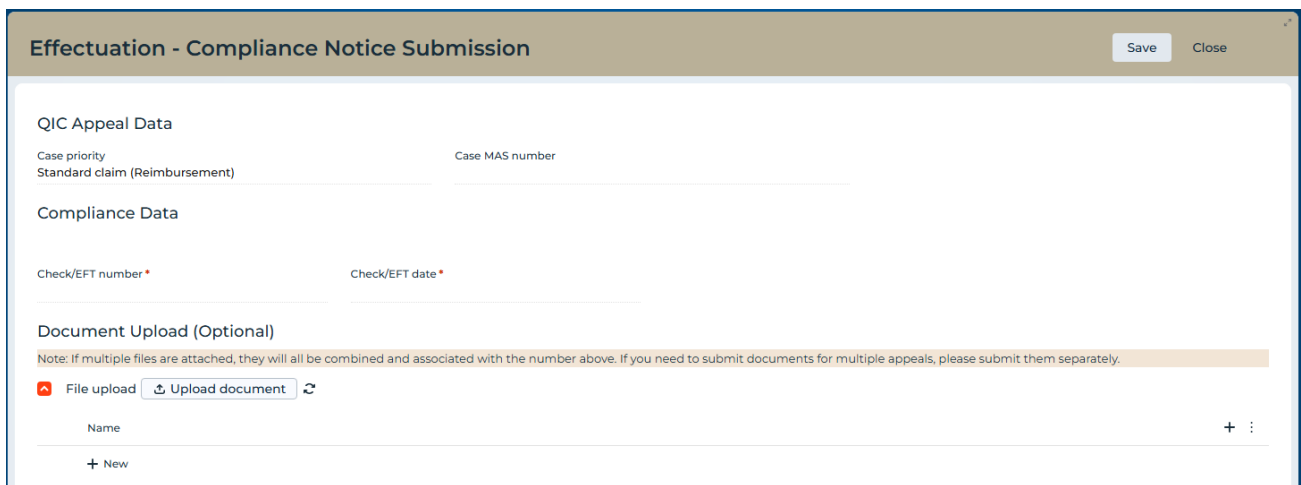
When clicked, a mini page window will open where the users will need to provide the details for the appeal. Either of the appeal number or the temporary Id can be provided.



If the appeal has not been previously submitted completely into the system, users will see an error displayed on the screen stating that Appeal Not found.



Otherwise, if it is an existing appeal, then the users will be prompted to the Effectuation – Compliance Notice Submission Page where additional information is needed along with an option to upload any documents.



This page has three sections:

QIC Appeal Data

The first section is QIC Appeal Data which displays the Priority and MAS Number for the appeal and are read-only fields.

Compliance Data

The second section is Compliance Data which depends upon the appeal priority, displays Authorization number and Authorization date, or Check/EFT number and Check/EFT date. All these are required fields.

Document Upload (optional)

The third section is Document Upload where users can upload any supporting documents using the “Upload document” button. Uploaded files are listed in this section. Users can then proceed to submit the request by clicking Save, and a confirmation message will be displayed on the screen.

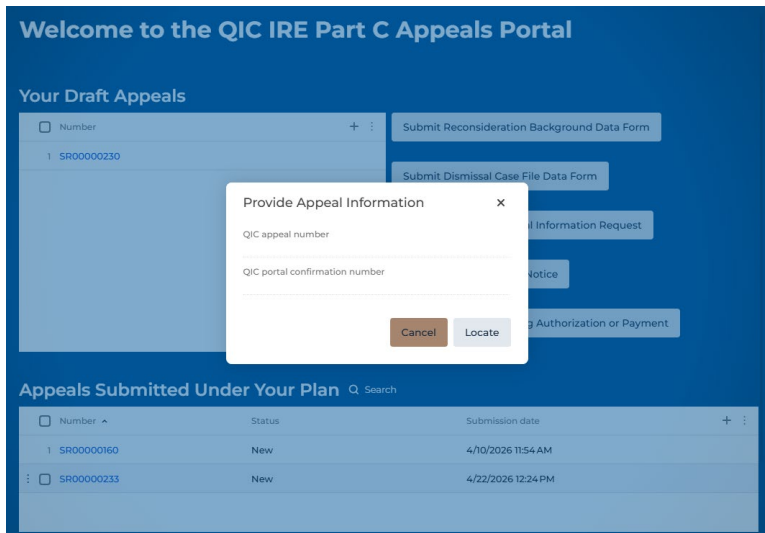
Plan Outreach Regarding Authorization or Payment

Plans can request a favorable decision, consistent with section 6.6.4 of the Reconsiderations Procedures Manual for an in-process appeal at the Part C QIC reconsideration based on authorization or payment for the services at issue.

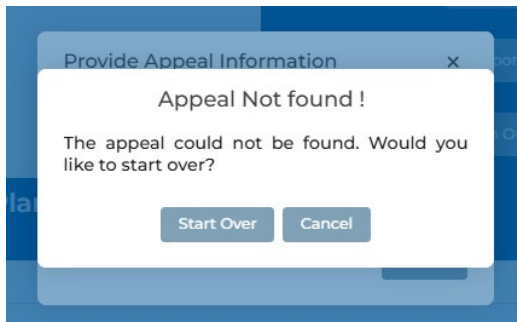
There are two ways users can provide the QIC with information regarding an authorized or paid for

item, service, or Part B Drug while an appeal is pending at the Part C QIC. One from the button “Submit Plan Outreach Regarding Authorization or Payment request” on the portal homepage and other, via clicking on the appeal in the list view under “Appeals Submitted Under Your Plan” label on the home page.

Once users click the respective button, a page will appear promoting users to either enter the temporary ID against their submitted appeal or the MAS number. The temporary ID is mapped as the QIC appeal confirmation number, and the MAS number is mapped as the QIC appeal number.



If either the Appeal Number or Temporary Id / Confirmation Number is incorrect, an error message will be displayed to the users stating – Appeal Not found.



Also, an error message will be displayed if a user tries to submit a dismissal request against an appeal which has not been submitted yet.

Given an appeal was submitted successfully and the either of the numbers – appeal number or confirmation numbers are correct, users will proceed to the “Plan Outreach Regarding Authorization or Payment” page.



This page has two sections:

Supporting Documents

In this section, users can click Upload supporting documents button to upload any supporting documents files. Once uploaded, these will be shown in the list view on the page.

Users are required to submit at least one supporting document to proceed with submitting the request.

Justification

In this section, the users are required to provide justification for the Plan Outreach Regarding Authorization or Payment request.

The users then can hit “Submit” to complete the request, and a confirmation message will be displayed on the screen, or the users can hit “Cancel” to exit the page altogether and not submit any request.

