

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM

1. CASE PRIORITY:

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

3. DISMISSAL REASON *(Complete if sending for dismissal)*

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

2. AMOUNT IN CONTROVERSY: \$ _____

4-a. ENROLLEE DATA

Enrollee Name: _____ HIC #: _____
 Enrollee Street: _____ Enrollee Phone: _____
 Enrollee City: _____ State: _____ Zip: _____

Enrollee Deceased? (Y/N) ____ *(if yes, complete #3 under 'Required Documentation' in section 4-c)*

Enrollee requires the final Determination Notice in a language other than English? No Yes: Language: _____

4-b. APPEAL REQUESTOR DATA

Appealing Party: *(check one)* Enrollee Enrollee's Estate Non-contract Provider Representative

Name: _____ Phone: _____

Company Name: _____

Street: _____

City: _____ State: _____ Zip: _____

4-c. REQUIRED DOCUMENTATION

- 1. Waiver of Liability Document for non-contract provider attached? Yes No
- 2. Appointment of Representative, POA or other representative document attached? Yes No
- 3. Has MHP included the verified enrollee's estate representation document in the case file? Yes No

4. If the MHP has verified that the appealing party is a Surrogate acting in accordance with State Law, and no Appointment Document is required, complete the following affidavit:

I attest on behalf of the MHP defined in Section 5 below, that the requesting party is a valid representative under State law:

Signed: _____ **Print Name:** _____

5. MEDICARE HEALTH PLAN (MHP) DATA

CMS Contract # *(required)*: _____

Address for Appeal Correspondence:

Street: _____

City: _____ State: _____

Zip: _____

Plan Name: _____

Plan Type: HMO MSA HCPP Regional PPO
 PSO Private FFS Plan Cost
 Local PPO Demo SNP

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

Contact Person Name: _____ E-mail: _____

Phone: _____

RI Fax: _____ Decision Letter Fax: _____

7. MHP ORGANIZATION DETERMINATION (Complete for all cases, including cases sent for dismissal.)

Enter Dates as MM/DD/YY

1) Date of Request for Organization Determination: ____/____/____

2) Date of Organization Determination: ____/____/____

3) Did enrollee or provider request an Expedited Organization Determination? Yes No

4) Was the request for the Expedited Organization Determination granted? Yes No

5) Did the MHP take a (14 day) extension? (If yes, include Notice of Extension in case file): Yes No

8. MHP RECONSIDERATION (Complete for all cases, including cases sent for dismissal.)

Enter Dates as MM/DD/YY

1) Date of Request for Reconsideration: ____/____/____

2) Date of Completion of MHP Reconsideration: ____/____/____

3) Did enrollee or provider make an Expedited Request for the MHP Reconsideration? Yes No

4) Was the request for the Expedited Reconsideration Determination granted? Yes No

5) Did the MHP take a (14 day) extension? (If yes, include Notice of Extension in case file): Yes No

9. PROVIDER IDENTIFICATION DATA (Complete a line for each provider described in the attached case file.)

Provider Name	Type	Specialty	In Area? (Y or N)	Relation to MHP	Medical Records	Dates Covered By Records From – To
(Name of PCP)						
1.						
(Other Providers Involved in Case)						
2.						
3.						
4.						
5.						

Type Codes		Relation to MHP Codes	Medical Record Codes
1. Hospital	5. Home Health Agency	1. PCP/Enrollee’s Primary Care Center	1. Included
2. SNF	6. Practitioner/Professional Corporation	2. Provider contracted with Enrollee’s MHP	2. Requested/refused
3. Other Facility	7. Vendor	3. Provider not contracted Enrollee’s MHP, but under referral	3. Requested/pending
4. Freestanding Clinic		4. Provider not contracted with the Enrollee’s MHP	4. Not requested

10. DEFINITION OF DENIED SERVICES OR CLAIMS (If more than one service is identified, use a separate line for each)

Item No.	Diagnosis/Condition under treatment	ICD-9-CM Diagnosis Code	Brief Description of Denied Item	Service Type Code	CPT or HCPCS Code(s)
1					
2					
3					

Service Type Codes (Note: Code each denied service above to the first category on this list which applies to the denied item)

- | | | | |
|--------------------------------|--------------------------|-------------------------|------------------------|
| 1. Out-of-Area Service | 6. Transportation | 10. Laboratory | 14. Chiropractic |
| 2. Emergency (in-area) Service | 7. DME | 11. Diagnostic Imaging | 15. Dental |
| 3. Home Health | 8. Medical Supplies | 12. Prescription Drugs | 16. Physician Services |
| 4. SNF | 9. Prosthetics/Orthotics | 13. Routine Vision Care | 17. Non-MD Service |
| 5. Hospital Inpatient | 18. Other: _____ | | |

Include the following documents in the case file:

A. 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**.

- I. CASE SUMMARY
- II. CHRONOLOGY OF CARE
- III. APPELLANT'S ARGUMENTS FOR COVERAGE
- IV. MHP RATIONALE FOR SERVICE OR CLAIM DENIAL
 - IV.A Summary Statement of Reason for Denial
 - IV.B Justification

B. MHP Notice Documents

- I. Organization Determination Notice (e.g. NDMC, NDP, NOMNC)
- II. Model Notice of Appeal Status

C. Documents used to reach MHP decision.

D. Evidence of Coverage (CD can be submitted)