MAXIMUS Federal

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

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 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)

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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 descriptionof 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 claimnumbers for dates of service as appropriate)
3. **Appellant's Arguments For Coverage**
4. **MHP Rationale For Denial**
5. **Justification** (i.e. citations to rules upon which plan denied coverage)
6. **Please indicate** if the **Following Documents** are included in the file

a. Organization Determination Notice with appeal rights ☐ Yes ☐ No
b. Notice of Appeal Status/Closure letter ☐ Yes ☐ No
c. Appeal Letter (or phone records if expedited request was made) ☐ Yes ☐ No
d. Evidence of Coverage* ☐ 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

*Please note: we encourage MHPs to submit these types of files in an electronic format on a CD. Please note: .PDF format is preferable.