

Part C Case File Submission - Output to SQID

Case Priority : **Standard Claim (Retrospective)**

Enrollee Data

Medicare Number (MBI) : **MBICME96IEV**

HIC# : **1HICklgTvXGjqsI**

First Name : **1Enrollee First Name02252019 1420**

Last Name : **1Enrollee Last Name02252019 1420**

Middle Initial : **N/A**

Address 1 : **1Enrollee Address 1**

Address 2 :

City : **1EnrolleeCity**

State : **PA**

Zip : **17651-0311**

Phone : **976-493-1344**

Enrollee deceased? : **No**

Date of Death : **N/A**

Request Received Date : **Mon Feb 25, 2019 at time 5:20 PM ET**

Plan Name : **weqwew**

CMS Contract # : **123322**

Medicare Plan Type : **PSO**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Lock-In/No Auth**

Other : **N/A**

QIC Appeal Number : **N/A**

Plan's Dismissal Reason : **N/A**

Other Plan's Dismissal Reason : **N/A**

Did the case involve a Medical Necessity Review? : **No**

Definition of Denied Services or Claims

Appeal Type : ***Testing**

Item/Service in dispute : **Other**

Other Item/Service Details : **Test of Other Item Service**

Is/Was the Enrollee in Hospice? : **No**

Hospice Election Date : **N/A**

Does the Enrollee require the final Determination Notice in a language other than English? : **No**

Language : **N/A**

Does the Enrollee require communication be made in any alternate format? : **No**

Required Format : **N/A**

Font Size : **N/A**

Other : **N/A**

Provider Identification Data

Services received/requested outside of the MHPs' geographic service area? : **N/A**

Services received/requested outside of MHPS's network of providers? : **N/A**

Services received/requested outside of Enrollee's medical group? : **N/A**

Dates of Service in Question : **Sun Oct 28, 2018 - Wed Nov 07, 2018**

Parties

Plan Information

Address 1 : **Kilgore Rd**

Address 2 :

City : **Rancho Cordova**

State : **CA**

Zip : **54645-6455**

Plan Contact

Plan Contact Person Name : **Ashok Ambrose**

First Name : **Ashok**

Last Name : **Ambrose**

Email : **ashok+6@gmail2.com**

Phone : **546-546-4646**

RI Fax Number : **546-545-6465**

Decision Letter Fax Number : **234-242-4242**

Plan Alternate Contact

First Name : **N/A**

Last Name : **N/A**

Phone Number : **N/A**

Appeal Request Information

Requestor Type : **Enrollee's Estate**

First Name : **1Appeal Requestor First Name**

Last Name : **1Appeal Requestor Last Name**

Middle Initial : **N/A**

Phone : **945-915-9678**

Company Name : **N/A**

Address1 : **1Appeal Requestor Address 1**

Address2 :

City : **1Appeal Requestor City**

State : **RI**

Zip : **65664-3195**

AOR Checked? : **N/A**

WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **Sat Nov 17, 2018**

Date of Plan's initial Denial : **Tue Nov 27, 2018**

Was an Expedited request made? : **N/A**

Was the Expedited request granted? : **N/A**

Did the plan take an extension? : **N/A**

MHP Reconsideration

Date of reconsideration request : **Fri Dec 07, 2018**

Date of plans reconsideration denial : **Mon Dec 17, 2018**

Was an Expedited request made? : **N/A**

Was the Expedited request granted? : **N/A**

Did the plan take an extension? : **N/A**

Amount in Controversy : **0**

Does the Enrollee require the final Determination Notice in a language other than English? : **No**

Other : **N/A**

Provider Identification Data

Field label - Enrollee's ICD-9/10 diagnosis code(s) applicable to the issues in this case :

Field label - HCPCS/CPT codes representing the items/services in dispute (Please do not substitute revenue codes for outpatient services) :