Part C Case File Submission - Output to SQID

Temporary Appeal Number : **Q19-00001230**
Case Priority : **Standard Service (Pre-Service)**

Enrollee Data

Medicare Number (MBI) : **MBIwoJ4WtIW**
HIC# : **1HICTl44g3wIZga**
First Name : **1Enrollee First Name08022019 1031**
Last Name : **1Enrollee Last Name08022019 1031**
Middle Initial : **N/A**
Address 1 : **1Enrollee Address 1**
Address 2 :
City : **1EnrolleeCity**
State : **WY**
Zip : **12757-9156**
Phone : **173-277-1812**

Enrollee deceased? : **N/A**
Date of Death : **N/A**
Request Received Date : **Fri Aug 02, 2019 at time 1:32 PM ET**
Plan Name : **weqwew**
CMS Contract # : **123322**
Medicare Plan Type : **Cost**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Appellant Dismissal Case File**
Other : **N/A**
QIC Appeal Number : **1-0681014289**
Is this case an Auto-Forward? : **Yes**
Plan's Dismissal Reason : **Not a Valid Rep of Estate**
Other Plan's Dismissal Reason : **N/A**
Did the case involve a Medical Necessity Review? : **Yes**

Definition of Denied Services or Claims

Appeal Type : ***Outpatient Therapies**
Item/Service in dispute : **Occupational Therapy**
Other Item/Service Details : **N/A**
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 : **N/A**

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 Treating Physician**
First Name : **1Appeal Requestor First Name**
Last Name : **1Appeal Requestor Last Name**
Middle Initial : **N/A**
Phone : **050-295-1023**
Company Name : **N/A**
Address1 : **1Appeal Requestor Address 1**
Address2 :
City : **1Appeal Requestor City**
State : **WY**
Zip : **91700-3946**
AOR Checked? : **N/A**
WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **Wed Apr 24, 2019**

Date of Plan's initial Denial : **Sat May 04, 2019**
Was an Expedited request made? : **Yes**
Was the Expedited request granted? : **No**
Did the plan take an extension? : **Yes**

MHP Reconsideration

Date of reconsideration request : **Tue May 14, 2019**
Date of plan's reconsideration denial : **Fri May 24, 2019**
Was an Expedited request made? : **Yes**
Was the Expedited request granted? : **No**
Did the plan take an extension? : **No**
Amount in Controversy : **N/A**
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) :