Part C Case File Submission - Output to SQID

Case Priority : **Standard Service (Pre-Service)**

Enrollee Data

Medicare Number (MBI) : **MBIYa2IFGqJ**
HIC# : **1HICKNYWEMeMJQp**
First Name : **1Enrollee First Name02272019 1202**
Last Name : **1Enrollee Last Name02272019 1202**
Middle Initial : **N/A**
Address 1 : **1Enrollee Address 1**
Address 2 :
City : **1EnrolleeCity**
State : **TN**
Zip : **98114-7737**
Phone : **504-027-6908**

Enrollee deceased? : **N/A**
Date of Death : **N/A**
Request Received Date : **Wed Feb 27, 2019 at time 3:07 PM ET**
Plan Name : **Test lk Legal Entity Name**
CMS Contract # : **qa123456**
Medicare Plan Type : **Dual SNP**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Other**
Other : **Test of other Issue Category**
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 : ***Home Health**
Item/Service in dispute : **Home Health Services**
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 : **HealthPlan addr1**
Address 2 :
City : **HealthPlan City**
State : **HI**
Zip : **96325-6666**

Plan Contact

Plan Contact Person Name : **HealthPlan TestQa**
First Name : **HealthPlan**
Last Name : **TestQa**
Email : **healthplan@gmail2.com**
Phone : **916-333-2222**
RI Fax Number : **916-333-2224**
Decision Letter Fax Number : **916-333-2223**

Plan Alternate Contact

First Name : **N/A**
Last Name : **N/A**
Phone Number : **N/A**

Appeal Request Information

Requestor Type : **Representative**
First Name : **1Appeal Requestor First Name**
Last Name : **1Appeal Requestor Last Name**
Middle Initial : **N/A**
Phone : **863-895-0483**
Company Name : **N/A**
Address1 : **1Appeal Requestor Address 1**
Address2 :
City : **1Appeal Requestor City**
State : **IN**
Zip : **34966-1075**
AOR Checked? : **No**
WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **Mon Nov 19, 2018**
Date of Plan's initial Denial : **Thu Nov 29, 2018**
Was an Expedited request made? : **Yes**

Was the Expedited request granted? : **Yes**
Did the plan take an extension? : **Yes**

MHP Reconsideration

Date of reconsideration request : **Sun Dec 09, 2018**
Date of plans reconsideration denial : **Wed Dec 19, 2018**
Was an Expedited request made? : **No**
Was the Expedited request granted? : **No**
Did the plan take an extension? : **Yes**
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) :