Part C Case File Submission - Output to SQID

Portal Confirmation Number : **Q19-00001178**
Case Priority : **Standard Claim (Retrospective)**

Enrollee Data

Medicare Number (MBI) : **MBIWAsf9Rsc**
HIC# : **1HICuLQNBUst6z3**
First Name : **1Enrollee First Name10302019 0958**
Last Name : **1Enrollee Last Name10302019 0958**
Middle Initial : **N/A**
Address 1 : **1Enrollee Address 1**
Address 2 :
City : **1EnrolleeCity**
State : **WI**
Zip : **09993-9372**
Phone : **410-022-7127**

Enrollee deceased? : **No**
Date of Death : **N/A**
Request Received Date : **Wed Oct 30, 2019 at time 12:58 PM ET**
Plan Name : **Helathy Blue**
CMS Contract # : **455**
Medicare Plan Type : **PFFS**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Cost Sharing**
Other : **N/A**
QIC Appeal Number : **N/A**
Is this case an Auto-Forward? : **Yes**
Plan's Dismissal Reason : **N/A**
Other Plan's Dismissal Reason : **N/A**
Did the case involve a Medical Necessity Review? : **Yes**

Definition of Denied Services or Claims

Appeal Type : ***DME/Orthotics**
Item/Service in dispute : **Walker**
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 : **Tue Jul 02, 2019 - Fri Jul 12, 2019**

Parties

Plan Information

Address 1 : **123 long street**

Address 2 :

City : **Milpitas**

State : **CA**

Zip : **12312-3123**

Plan Contact

Plan Contact Person Name : **Ginu John**

First Name : **Ginu**

Last Name : **John**

Email : **johngeethu+qicportal@gmail.com**

Phone : **408-644-4905**

RI Fax Number : **242-432-4234**

Decision Letter Fax Number : **234-234-2342**

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 : **649-303-6319**

Company Name : **N/A**

Address1 : **1Appeal Requestor Address 1**

Address2 :

City : **1Appeal Requestor City**

State : **NY**

Zip : **38618-2349**

AOR Checked? : **N/A**

WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **Mon Jul 22, 2019**

Date of Plan's initial Denial : **Thu Aug 01, 2019**
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 : **Sun Aug 11, 2019**
Date of plan's reconsideration denial : **Wed Aug 21, 2019**
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) :