# Part C Case File Submission - Output to SQID

Portal Confirmation Number : **Q19-00001164**
Case Priority : **Standard Service (Pre-Service)**

## Enrollee Data

Medicare Number (MBI) : **MBIcSyC65c2**
HIC# : **1HICJQrJ7QquAqA**
First Name : **1Enrollee First Name10292019 1607**
Last Name : **1Enrollee Last Name10292019 1607**
Middle Initial : **N/A**
Address 1 : **1Enrollee Address 1**
Address 2 :
City : **1EnrolleeCity**
State : **SD**
Zip : **40354-3330**
Phone : **105-987-3241**

Enrollee deceased? : **N/A**
Date of Death : **N/A**
Request Received Date : **Tue Oct 29, 2019 at time 7:08 PM ET**
Plan Name : **ABC Entity**
CMS Contract # : **12333**
Medicare Plan Type : **Local PPO**

### Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Supplemental Benefit**
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 : ***Inpatient Hospital**
Item/Service in dispute : **LTACH**
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 : **N/A**
Address 2 : **N/A**
City : **N/A**
State : **N/A**
Zip : **N/A**

## Plan Contact

Plan Contact Person Name : **Addison Sutter**
First Name : **Addison**
Last Name : **Sutter**
Email : **addison@sutter.com**
Phone :
RI Fax Number : **916-503-5014**
Decision Letter Fax Number : **916-503-5014**

### Plan Alternate Contact

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

## Appeal Request Information

Requestor Type : **Enrollee**
First Name : **1Enrollee First Name10292019 1607**
Last Name : **1Enrollee Last Name10292019 1607**
Middle Initial : **N/A**
Phone : **105-987-3241**
Company Name : **N/A**
Address1 : **1Enrollee Address 1**
Address2 :
City : **1EnrolleeCity**
State : **SD**
Zip : **40354-3330**
AOR Checked? : **N/A**
WOL Checked? : **N/A**

## MHP Organization Determination

Date of initial authorization request or claim submission : **Sun Jul 21, 2019**

Date of Plan's initial Denial : **Wed Jul 31, 2019**
Was an Expedited request made? : **No**
Was the Expedited request granted? : **No**
Did the plan take an extension? : **No**

## MHP Reconsideration

Date of reconsideration request : **Sat Aug 10, 2019**
Date of plan's reconsideration denial : **Tue Aug 20, 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) :