

## Part C Case File Submission - Output to SQID

Temporary Appeal Number : **Q19-00001030**

Case Priority : **Expedited**

### Enrollee Data

Medicare Number (MBI) : **MBIpR4Y3ZCi**

HIC# : **1HICcV2dJYyDE6D**

First Name : **1Enrollee First Name08212019 1652**

Last Name : **1Enrollee Last Name08212019 1652**

Middle Initial : **N/A**

Address 1 : **1Enrollee Address 1**

Address 2 :

City : **1EnrolleeCity**

State : **DC**

Zip : **65025-4945**

Phone : **799-538-2466**

Enrollee deceased? : **N/A**

Date of Death : **N/A**

Request Received Date : **Wed Aug 21, 2019 at time 7:52 PM ET**

Plan Name : **ABC Entity**

CMS Contract # : **12333**

Medicare Plan Type : **Cost**

### 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? : **No**

### Definition of Denied Services or Claims

Appeal Type : **\*Practitioner Services**

Item/Service in dispute : **Out of Area**

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 : **3140 Data Dr**

Address 2 :

City : **Rancho Cordova**

State : **CA**

Zip : **95640**

## 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 : **Surrogate acting in accordance with the State law**

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

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

Middle Initial : **N/A**

Phone : **863-048-3549**

Company Name : **N/A**

Address1 : **1Appeal Requestor Address 1**

Address2 :

City : **1Appeal Requestor City**

State : **DC**

Zip : **09520-7886**

AOR Checked? : **N/A**

WOL Checked? : **N/A**

## MHP Organization Determination

Date of initial authorization request or claim submission : **Mon May 13, 2019**

Date of Plan's initial Denial : **Thu May 23, 2019**

Was an Expedited request made? : **No**

Was the Expedited request granted? : **Yes**

Did the plan take an extension? : **No**

### MHP Reconsideration

Date of reconsideration request : **Sun Jun 02, 2019**

Date of plan's reconsideration denial : **Wed Jun 12, 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) :