Part D - Case File Transmittal Form

Submission Received: **Wed May 08, 2019 at time 6:44 PM ET**

Appeal Information:

Appeal Priority: **Standard**

Appeal Type: **Retrospective**

Is this case an Auto-Forward?: **No**

QIC Appeal Number: **2-334234237**

Applicable Coverage Year(s): **1390, 2000, 2010**

Does this case involve a cost sharing issue?: **No**

Auto-Forward :

Please select the level at which the processing time was missed: **N/A**

Health Plan Info :

Contract Number: **qa123456**

Plan Name: **Test lk Legal Entity Name**

Plan Type: **MA-PD**

Other: **N/A**

Plan Id: **sfdsf**

Formulary Name/ID: **dfsdfsdf**

The Health Plan Contact Information :

First Name: **Associate1003**

Last Name: **1003Last**

Address Line 1: **111**

Address Line 2 (Optional): **222**

City: **ccc**

State: **AZ**

Zip Code: **11111**

Email Address: **associatedPlan1003@gmail55.com**

Phone: **333-222-6655**

Decision Letter Fax: **333-222-1122**

Request for Information Fax: **333-222-9900**

Requestor Information

Select Requestor: **Enrollee's Prescribing Physician**

Is estate documentation in the file?: **N/A**

Is an AOR or Power of Attorney in the File?: **N/A**

Representative Information

First Name: **N/A**

Last Name: **N/A**

Address Line 1: **N/A**

Address Line 2 (Not Required): **N/A**

City: **N/A**

State: **N/A**
Zip Code: **N/A**
Email Address: **N/A**
Phone: **N/A**
Fax Number: **N/A**

Plan Attestation for Representative

"I attest on behalf of the Part D Plan sponsor that the above referenced representative appealed at the Plan level and is a valid representative of the enrollee under State law."
Portal User: **N/A**

Enrollee Information

First Name: **fdsfsdf**
Last Name: **dfssdf**
Address Line 1: **dsfdsf**
Address Line 2 (optional):
City: **sdfdsf**
State: **KS**
Zip Code: **23423-4234**
Phone: **234-234-2342**
Medicare Number (MBI) : **31313131313**
Health Insurance Claim #: **N/A**

Language preference

Does the Enrollee require the Reconsideration Notice to be in a language other than English?**No**
Please select a language:**N/A**
Other Language:**N/A**

Communication Preference

Does the Enrollee require communication be made in any alternate format?**No**
Required Format: **N/A**
Font Size:**N/A**
Other:**N/A**

Plan level

Plan Level 0 Coverage Determination

Date Coverage Determination was requested: **Tue May 07, 2019**
Decision Date: **N/A**
Was Coverage Determination untimely? :**No**
Was a decision made at this level? :**No**
Did appellant ask the Plan to expedite?: **No**
Did the Plan grant an expedited review?: **No**

Exceptions

Does the determination involve an Exceptions Request?: **N/A**

Did the Plan extend the maximum time frames to obtain a prescriber statement?: **N/A**

Date prescriber statement was requested: **N/A**

Was it received?: **N/A**

Date prescriber statement was received: **N/A**

Plan Level 1 Redetermination

Date Redetermination was requested: **Thu May 02, 2019**

Decision Date: **N/A**

Was Coverage Determination untimely? :**No**

Was a decision made at this level?: **No**

Did appellant ask the Plan to expedite?: **No**

Did the Plan grant an expedited review?: **No**

Prescriber Information

First Name: **kjhkjh**

Last Name: **kjhkjh**

Suffix:

Address Line 1: **hjkhkjh**

Address Line 2 (Not Required):

City: **jhkjh**

State: **KY**

Zip Code: **76567-5756**

Office Phone Number: **675-765-6757**

Office Fax Number: **576-576-5765**

Drug Details (Drug Benefits in Dispute)

Number: 1

National Drug Code (NDC):

Drug Name: **khkhkj**

Strength/ Dosage/ Amount: **8/ /**

Type: **both**

Off-Formulary: **No**

Denial Rationale: **Excluded drug/use**

Explanation of Rationale: **N/A**

What type of coverage is requested for this drug?: **Prospective**

Has the Enrollee purchased the Drug pending appeal?: **No**

Was the Drug(s) purchased from a network pharmacy?: **N/A**

Explanation: **N/A**

Has this drug been approved as requested?: **No**

Exhibit Instructions

Procedural Documentations

☑ A. Case Narrative cover page the presents an overview of the appeal: Describe the issue on the appeal; Identify all relevent

information;Identify arguments presented in favor of coverage; and explain the Plain rationale for denial

☐ B. Request for Coverage Determination and Plan Coverage Decision Notice

☐ C. Request for Redetermination and Plan Redetermination Decision Notice

☐ D. Prescriber statement (for exception requests)

☐ E. Prior Authorization Form or Exception Request Form

☐ F. Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State Law, estate representative

☐ G. Other (additional documents the Plan considers important)

Evidentiary Documentation

☐ H. Part D Plan Comprehensive Formulary for Plan year(s) at issue

☐ I. Part D Plan Evidence of Coverage or other subscriber materials for Plan year(s) at issue

☐ J. Cost Sharing Information (copies of internal Plan documents/ screens showing TrOOp or other relevant cost-sharing information)

☐ K. Medical Records

☐ L. Medicare Rules (Medicare law and regulations, CMS manuals, and/or CMS program guidance as relevant to the Pard D Plan's Determination)

☐ M. Redetermination Evidence (evidence submitted by appellant and /or prescriber, and internal Plan medical reviews conducted to evaluate medical issues)

☐ N. Universal Claim form for a compound drug

☐ O. Other (additional documents the Plan considers important)

Overview of Issues:

Timeline of Facts: