

Part C Case File Submission - Output to SQID

Temporary Appeal Number : **Q19-00001003**

Case Priority : **Standard Claim (Retrospective)**

Enrollee Data

Medicare Number (MBI) : **MBIpJ8cqPnq**

HIC# : **1HICW83TP2K41WQ**

First Name : **1Enrollee First Name08192019 1615**

Last Name : **1Enrollee Last Name08192019 1615**

Middle Initial : **N/A**

Address 1 : **1Enrollee Address 1**

Address 2 :

City : **1EnrolleeCity**

State : **RI**

Zip : **86718-6131**

Phone : **130-449-1689**

Enrollee deceased? : **No**

Date of Death : **N/A**

Request Received Date : **Mon Aug 19, 2019 at time 7:16 PM ET**

Plan Name : **ABC Entity**

CMS Contract # : **12333**

Medicare Plan Type : **HMO**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Other**

Other : **Test of other Issue Category**

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 : **Sun Apr 21, 2019 - Wed May 01, 2019**

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 : **825-270-3112**

Company Name : **N/A**

Address1 : **1Appeal Requestor Address 1**

Address2 :

City : **1Appeal Requestor City**

State : **AS**

Zip : **86599-9578**

AOR Checked? : **N/A**

WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **Sat May 11, 2019**

Date of Plan's initial Denial : **Tue May 21, 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 : **Fri May 31, 2019**

Date of plan's reconsideration denial : **Mon Jun 10, 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) :