Part C Case File Submission - Output to SQID

Portal Confirmation Number : **Q19-00001392**
Case Priority : **Standard Claim (Retrospective)**

Enrollee Data

Medicare Number (MBI) : **MBIBWI9dLFH**
HIC# : **1HICgdQ5NowE5oi**
First Name : **1Enrollee First Name11042019 1201**
Last Name : **1Enrollee Last Name11042019 1201**
Middle Initial : **N/A**
Address 1 : **1Enrollee Address 1**
Address 2 :
City : **1EnrolleeCity**
State : **MS**
Zip : **54833-3625**
Phone : **433-923-3195**

Enrollee deceased? : **No**
Date of Death : **N/A**
Request Received Date : **Mon Nov 04, 2019 at time 3:04 PM ET**
Plan Name : **Test lk Legal Entity Name**
CMS Contract # : **QA123456**
Medicare Plan Type : **NY FIDA**

Appeal Category & Appeal Type/Item Service

Issue Category/Item Service Category : **Appellant Dismissal Case File**
Other : **N/A**
QIC Appeal Number : **1-6822399440**
Is this case an Auto-Forward? : **Yes**
Plan's Dismissal Reason : **Waiver of Liability Missing**
Other Plan's Dismissal Reason : **N/A**
Did the case involve a Medical Necessity Review? : **No**

Definition of Denied Services or Claims

Appeal Type : ***DME/Orthotics**
Item/Service in dispute : **Compression Stockings**
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 Jul 07, 2019 - Wed Jul 17, 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**

First Name : **1Enrollee First Name11042019 1201**

Last Name : **1Enrollee Last Name11042019 1201**

Middle Initial : **N/A**

Phone : **433-923-3195**

Company Name : **N/A**

Address1 : **1Enrollee Address 1**

Address2 :

City : **1EnrolleeCity**

State : **MS**

Zip : **54833-3625**

AOR Checked? : **N/A**

WOL Checked? : **N/A**

MHP Organization Determination

Date of initial authorization request or claim submission : **N/A**

Date of Plan's initial Denial : **N/A**
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 : **N/A**
Date of plan's reconsideration denial : **N/A**
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) :