

MEDICARE MANAGED CARE RECONSIDERATION BACKGROUND DATA FORM

1. CASE PRIORITY:

- Expedited
- Standard Service (Pre-authorization)
- Standard Claim (Reimbursement)

2-a. AMOUNT IN CONTROVERSY: \$ _____

2-b. DATE(S) OF SERVICE IN QUESTION: _____

2-c. DOES THIS CASE INVOLVE A COST SHARING ISSUE?
 Yes No

3. ENROLLEE DATA

Enrollee Name: _____ **HIC:** _____

Enrollee Street: _____ **Enrollee Phone:** _____

Enrollee City: _____ **State:** _____ **Zip:** _____

Is the Enrollee Deceased? No Yes- Date of Death ____/____/____

Is the Enrollee in Hospice? No Yes- Date of Election ____/____/____ (election form must be provided)

Does the Enrollee require the final Determination Notice in a language other than English?

No Yes _____ (specify language)

Does the Enrollee require communication be made in any alternate format?

No Yes _____ (specify type of format below)

Large Print (if other than 18 point font, indicate size below) Audio CD Braille Qualified Reader

Other _____ (specify type of format or font)

4. APPEAL REQUESTOR DATA (check one)

- Enrollee is Requestor**
- Enrollee's treating physician (no AOR required for Expedited or Standard Service cases)
- Enrollee's Estate Is Estate Documentation in File? Yes No
- Non-Contract Provider (payment cases only) Is a Waiver of Liability in File? Yes No
- Representative Is an AOR or Power of Attorney in File? Yes No
- Surrogate acting in accordance with State Law Yes No

Name of Requestor: _____ **Phone:** _____

Company Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

5. MEDICARE HEALTH PLAN (MHP) DATA

CMS Contract # (REQUIRED): _____

- Plan Name:** _____
- Plan Type:**
- HMO
 - MSA
 - HCPP
 - Cost
 - PSO
 - Local PPO
 - Regional PPO
 - Demo
 - PFFS
 - SNP
 - PACE
 - MMP
 - MMP-NY FIDA

Address for Appeal Correspondence:

Street: _____

City: _____

State: _____ **Zip:** _____

6. MHP CONTACT PERSON FOR THIS RECONSIDERATION

Contact Person Name: _____ Email: _____
 Phone: _____
 RI Fax Number: _____ Decision Letter Fax Number: _____
 Alternate Contact Person or Supervisor Name: _____ Phone: _____

7. MHP ORGANIZATION DETERMINATION (Complete for all cases)

- a. Date of Initial Authorization request or claim submission _____ / ____ / ____
- b. Date of Plan's initial Denial (Organization Determination) _____ / ____ / ____
- c. Was an Expedited request made? Yes No
- d. Was the expedited request granted? Yes No
- e. Did the plan take an extension? (If so, please provide notice in file) Yes No

8. MHP RECONSIDERATION (Complete for all cases)

- a. Date of Reconsideration Request _____ / ____ / ____
- b. Date of Plan's Reconsideration Determination _____ / ____ / ____
- c. Was an Expedited request made? Yes No
- d. Was the expedited request granted? Yes No
- e. Did the plan take an extension? (If so, please provide notice in file) Yes No

9. PROVIDER IDENTIFICATION DATA- Please List All Providers applicable to this appeal, including referring providers

Provider Name(s)	Specialty	Records Requested?	Records Provided?	Contract Provider?
1. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Services received/requested outside of the MHP's geographic service area? Yes No
 Services received/requested outside of MHP's network of providers? Yes No
 Services received/requested outside of Enrollee's medical group? Yes No N/A

10. DEFINITION OF DENIED SERVICES OR CLAIMS

Item/service in dispute _____

Enrollee's ICD-9/10 diagnosis code(s) applicable to the issues in this case: _____

HCPCS/CPT codes representing the items/services in dispute _____
 (Please do not substitute revenue codes for outpatient hospital services) _____

CASE NARRATIVE OUTLINE (Attach to file as a document separate from the Background Data Form)

Please note, if the reason for coverage denial is that covered services must be given by **a contracted provider who is associated with a specific PCP group/network** it is important that you **include that information in the case file narrative**.

1. **CASE SUMMARY** (Please make sure to include the following: Enrollee name, age, sex, specific plan (i.e., Value plan vs. Deluxe Plan) and information about any supplemental riders that the enrollee may have, in addition to a description of the item/service in dispute)
2. **CHRONOLOGY OF CARE** (This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates of service as appropriate)
3. **APPELLANT’S ARGUMENTS FOR COVERAGE**
4. **MHP RATIONALE FOR DENIAL**
5. **JUSTIFICATION** (i.e. citations to rules upon which plan denied coverage)

6. Please indicate if the Following Documents are included in the file

- | | | |
|---|------------------------------|-----------------------------|
| a. Organization Determination Notice <u>with appeal rights</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Notice of Appeal Status/Closure letter | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Appeal Letter (or phone records if expedited request was made) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. *Evidence of Coverage | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Criteria used to reach decision | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Medical Records (legible) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Original X-rays, Digital X-ray prints, Photographs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*Please note: we encourage MHPs to submit these types of files in an electronic format on a CD. Please note: .PDF format is preferable.