

MAXIMUS Federal

Medicare Managed Care Reconsideration Background Data Form

1. Case Priority: Expedited
 Standard Service (Pre-authorization)
 Standard Claim (Reimbursement)
- 2a. Amount In Controversy: \$ _____
2b. Date(s) Of Service In Question: _____
2c. Does This Case Involve A Cost Sharing Issue? Yes No
2d. Is This Case An Auto Forward? Yes No

3. Enrollee Data

Enrollee Name: _____ HIC: _____
Enrollee Street: _____ MBI: _____
Enrollee City: _____ State: _____ Zip: _____ Enrollee Phone: _____

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) _____

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: _____ City: _____

Street: _____ State: _____ Zip: _____

5. Medicare Health Plan (MHP) Data

Address for Appeal Correspondence:

CMS Contract # (required): _____ Street: _____

Plan Name: _____ City: _____ State: _____ Zip: _____

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

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