MAXIMUS Federal

Medicare Managed Care Reconsideration Background Data Form

1. Case Priority:

- ☐ Expedited
- ☐ Standard Service (Pre-authorization)
- ☐ Standard Claim (Reimbursement)
- ☐ Standard Service Part B Drug request (pre-authorization)

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 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) _____

☐ 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

CMS Contract # (**required**): _____

Plan Name: _____

Plan Type: ■ HMO ■ PSO ■ Demo ■ MMP ☐ MSA ■ HCPP ■ SNP ■ Cost ■ Local PPO ■ Regional PPO ■ PFFS ☐ PACE ■ 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. _____	_____	■ Yes ■ No	■ Yes ■ No	■ Yes ■ No
2. _____	_____	■ Yes ■ No	■ Yes ■ No	■ Yes ■ No
3. _____	_____	■ Yes ■ No	■ Yes ■ No	■ Yes ■ No
4. _____	_____	■ Yes ■ No	■ Yes ■ No	■ Yes ■ 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 condition related to the 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 descriptionof 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 claimnumbers 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.