MEDICARE MANAGED CARE DISMISSAL CASE FILE DATA FORM MAXIMUS CASE NUMBER_____

1. CASE PRIORITY: Expedited Standard Service (Pre-service) Standard Claim (payment)	2. DATE(S) OF SERVICE IN QUESTION:		3. PLAN'S DISMISSAL REASON Untimely Filing of Appeal Waiver of Liability missing Not an Authorized Rep Not a Valid Rep of Estate Other	
4-a. ENROLLEE DATA				
Enrollee Name:	HIC:	Enrolle	ee Phone:	
Street Address:	_City:	State:	_ Zip:	
Does the Enrollee require the Dismissal Do	etermination Notice in a language other than English?	No Yes	(specify language)	
4-b. REQUESTOR DATA (i.e., person/entity requesting the dismissal review) (check one) Enrollee Enrollee's Treating Physician Enrollee's Estate Non-Contract Provider Surrogate acting in accordance with State Law				
Name of Requestor:		Phone:		
Street:	City:	State:	Zip:	
5. MEDICARE HEALTH PLAN (MHP) DATA		or Dismissal Review Cor	respondence:	
CMS Contract # (REQUIRED):	Street:			
Plan Name:	City:		_State:Zip:	
6. MHP CONTACT PERSON FOR THIS DIS	MISSAL REVIEW			
Contact Person Name:	Email:	Phone:		
Fax Number:	Alternate Contact Person or Supervisor Nam		Phone:	

DISMISSAL CASE FILE NARRATIVE

1.	DISMISSAL CASE SUMMARY				
2.	DISMISSAL CHRONOLOGY (This should be a brief overview of the timeline of events in this case. Please refer to claim numbers for dates service as appropriate)	S 0			
3.	MHP DISMISSAL RATIONALE				
4.	JUSTIFICATION (i.e. citations to rules upon which plan dismissed)				
5.	Please indicate if the following documents are included in the file				
	a. Correspondence of attempts to get representative documentation/WOL (if applicable) b. Notice of Dismissal c. Appeal Letter (or phone records if expedited request was made) d. Documentation regarding the plan's assessment of good cause (if applicable) Yes No No				