

# How to complete the Part D QIC Reconsideration Case File Transmittal Form

The Part D Plan or Plan Sponsor must ensure each case file meets CMS and MAXIMUS Federal Services standards for completeness and accuracy.

Forms and procedures can be found at: [www.medicarepartdappeals.com](http://www.medicarepartdappeals.com)

## Page 1

The Part D Plan or Plan Sponsor can call their Plan Liaison for necessary assistance:

**PDP Plans** - contact:  
Alè Yekpabo  
484-688-5645

**MA-PD Plans** - contact:  
Suzan M. Elzey  
585-425-5306.

The Part D Plan is the Plan that provides the Part D drug benefit coverage for the enrollee.

Enter the name of the appealing party under Appellant Name.

Enter the name of the person who is enrolled under Enrollee Name.

Ensure the correct HIC/Medicare Claim Number is entered here.

Enter the most current enrollee address and phone number here.

Complete this section in its entirety.

Most of the MAXIMUS Federal Services correspondence are sent to the contact information shown in this section.

If you are unsure of your plan contract #, contact your CMS representative.

Please indicate the appropriate Formulary ID #.

If the enrollee has appointed a representative, complete this section. Don't forget to sign and print your name.

It is very important that you send us the proper Plan address. MAXIMUS Federal Services sends decision letters to this address, along with the Notice of Effectuation form for favorable decisions.

**Note:** If a company is administering the claim (such as a PBM) the Plan Address is where all notices for compliance and effectuation will be sent.

**CMS** | **MAXIMUS** Federal Services

**PART D QIC RECONSIDERATION CASE FILE TRANSMITTAL FORM**

Name of Part D Plan: \_\_\_\_\_

Date of Redetermination Notice: \_\_\_\_\_

**Appeal Information:** (Check one for each line)

a. Priority:  Expedited  Standard

b. Appeal Type:  Prospective  Retrospective

c. Auto-forward:  Yes  No

Appellant Name	Enrollee Name

Enrollee HIC/Medicare Claim Number	Date of Birth

Enrollee Address and Phone Number: \_\_\_\_\_

**Part D Plan Information:**

Plan Type:  PDP (S#)  MA-PD (H or R#)  Cost

Plan Contract# (H/S/R) \_\_\_\_\_ (Circle "H" "S" or "R" and list the 4 digit CMS Plan Contract #)

Plan ID # \_\_\_\_\_ Formulary Name/Formulary ID # \_\_\_\_\_

Plan Contact (Name/Title) \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

Plan Address \_\_\_\_\_

**Representative Appeals:** (\*\*\*NOTE: Representative documents MUST be included in case file\*\*\*)

Name of Representative \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

**PLAN ATTESTATION FOR VALIDITY OF REPRESENTATIVE**

I attest on behalf of the Part D Plan sponsor that the above referenced representative appealed at the Plan level and is a valid representative of the enrollee under State law.

Signed \_\_\_\_\_ Print Name \_\_\_\_\_



Requested coverage at CD level  Appealed at RD level

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You must print and complete Page 2 for EACH drug in dispute.

A Pre-Service request involves coverage for future prescriptions for a drug as well as any purchases the enrollee has already made of that particular drug.

A Retrospective request only involves coverage for drug purchases the enrollee has already made.

*\*If multiple drugs in dispute, print and complete a separate version of this page for each drug in dispute*

**Plan Level Appeal Information:**

**Coverage Determination (CD):**  
 Date Requested: \_\_\_\_\_ Decision Date: \_\_\_\_\_ Was CD Timely?  YES  NO  
 Did Appellant Ask Plan To Expedite?  YES  NO Did Plan Expedite?  YES  NO

**Redetermination (RD):**  
 Date Requested: \_\_\_\_\_ Decision Date: \_\_\_\_\_ Was RD Timely?  YES  NO  
 Did Appellant Ask Plan To Expedite?  YES  NO Did Plan Expedite?  YES  NO

**For Determinations Involving an Exceptions Request:**  
 Is the Prescribing Physician Statement in the Case File?  YES  NO

**Drug Benefit in Dispute:**

Name of Drug \_\_\_\_\_  
 Quantity/Dosage (e.g. 20 mg BID) \_\_\_\_\_  
 Is Prescriber Requesting:  Brand  Generic  Either Acceptable (Check one)  
 Off-Formulary?  Yes  No

**Pre-Service Requests:** Has Enrollee Purchased the Drug Pending Appeal?  Yes  No  
 If YES: Date Purchased: \_\_\_\_\_ Amount Paid: \_\_\_\_\_  
 Purchased From Network Pharmacy?  Yes  No

**Retrospective Requests:** Date(s) of Purchase: \_\_\_\_\_ Drug Tier: \_\_\_\_\_  
 Amount(s) Paid: \_\_\_\_\_  
 Purchased From Network Pharmacy?  Yes  No  
 If NO, explain: \_\_\_\_\_

**Drug Benefit Denial Rationale:**

PA rules not met  Step Therapy exception rules not met  
 Dose/OL exception rules not met  Brand/Generic Cost Differential exception rules not met  
 PA exception rules not met  Off-Formulary exception rules not met  
 Tiering exception rules not met  Out-of-Network rules not met  
 Excluded Drug Class/Use  Covered Under A/B  
 Cost-Sharing Dispute  Not a Medically Accepted Indication  
 Other \_\_\_\_\_

**Prescriber Information:**



Name/Specialty of Physician \_\_\_\_\_  
 Office Address \_\_\_\_\_  
 Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_  
 Prior Authorization Form Submitted?  Yes  No

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Be sure to check the appropriate boxes and submit Page 3 with the rest of the Case File Transmittal Form.

**REMEMBER:**

- Include a copy of the pages, or sections, from the documents that the Plan relied on to make its decision—include the specific sections from the formulary, subscriber materials, cost sharing information, medical records, Medicare rules, redetermination evidence, and any other materials that were the basis for the Plan's denial.

**Exhibits: Label applicable exhibits with letters provided below, and place them in order by letter.**

Procedural Documents	<input type="checkbox"/> A. Case Narrative cover page that presents an overview of the appeal: Describe the issue on appeal; Identify all relevant information; Identify the arguments presented in favor of coverage; and Explain the Plan rationale for denial.
	<input type="checkbox"/> B. Request for Coverage Determination and Plan Coverage Determination Decision Notice
	<input type="checkbox"/> C. Request for Redetermination and Plan Redetermination Decision Notice
	<input type="checkbox"/> D. Prescribing Physician Statement (for exceptions requests)
	<input type="checkbox"/> E. Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State law, estate representative)
Evidentiary Documents	<input type="checkbox"/> F. Other (describe or list additional exhibits the Plan considers important)
	<input type="checkbox"/> G. Part D Plan Formulary (relevant exceptions and/or coverage criteria)
	<input type="checkbox"/> H. Part D Plan Evidence of Coverage or other Subscriber Materials (relevant portions)
	<input type="checkbox"/> I. Cost Sharing Information (copies of internal Plan documents/screens showing TrOOP or other cost-sharing information as relevant to the dispute).
	<input type="checkbox"/> J. Medical Records (separated by physician, labeled, and in chronological order with most recent on top).
	<input type="checkbox"/> K. Medicare Rules (Medicare law and regulations, CMS manuals, and/or CMS program guidance as relevant to the Part D Plan's determination).
<input type="checkbox"/> L. Redetermination Evidence (evidence submitted by appellant and/or the prescribing physician, and internal Plan medical reviews conducted to evaluate medical necessity issues)	
<input type="checkbox"/> M. Other (describe or list additional exhibits the Plan considers important).	

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