**Request for Redetermination of Medicare Prescription Drug Denial**

[Part D plan sponsor] denied your request for coverage of (or payment for) [name of prescription drug]. You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

* You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
* You can also file an appeal through our website at [plan web address].
* Expedited appeal requests can be made by phone at [plan telephone number].

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at [plan telephone number] to learn how to name a representative.

**Plan enrollee information**

Enrollee name:

Member ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address:

City, State, ZIP code:

Phone:

**Prescription & prescriber information**

Name of drug you asked for:

Strength/quantity/dose:

Prescriber name:

Office address:

City, State, ZIP code:

Office phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office contact person:

Did you already purchase this drug?  Yes  No

If YES:

Date purchased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount paid:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (attach copy of receipt)

Pharmacy name:

Pharmacy phone number:

**Do you need an expedited (fast) decision?**

**Check this box if you believe you need a decision within 72 hours.** If you have a supporting statement from your prescriber, attach it to this request.

* If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.
* If your prescriber indicates that waiting 7 days could seriously harm your health, we’ll automatically give you a decision within 72 hours. You can’t ask for an expedited appeal if you’re asking us to pay you back for a drug you already got.
* If you don’t get your prescriber's support for an expedited appeal, we’ll decide if your case requires a fast decision.

**Explain why you think this drug should be covered**

* Attach any additional information you think may help your case, like statement from your prescriber or medical records.
* Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
* Your prescriber will need to explain why you can’t meet our plan’s coverage rules and/or why the drugs required by the plan aren’t medically appropriate for you.
* Other information we should consider:

**Representative information**

Complete this section ONLY if the person making this request is not the enrollee or the enrollee’s prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn’t submitted at the coverage determination level. For more information on appointing a representative, Call us at [plan telephone number].

Representative name:

Relationship to enrollee:

Street address:

City, State, ZIP code:

Phone:

**Sign & submit this form**

Signature of person requesting the appeal (the enrollee, prescriber or representative):

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax or mail your completed form and any supporting information to:**

**Address:** **Fax Number:**

[Insert plan address(es)] [Insert plan fax number(s)]