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

Because we HM Health Insurance Company denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address: **Standard Redetermination:** Appeals & Grievance Department P.O. Box 535047 Pittsburgh PA 15253-5047 Fax Number: **Standard Redetermination:** 1-717-635-4209

## Expedited Redetermination:

Expedited Redetermination: 1-800-894-7947

Expedited Review Department P.O. Box 535073 Pittsburgh PA 15253-5073

You may also ask us for an appeal through our website at <u>www.highmarkblueshield.com</u>

Expedited appeal requests can be made by phone at 1-800-485-9610, TTY 1-888-422-1226.

**Who May Make a Request:** Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information				
Enrollee's Name		Date of Birth		
Enrollee's Address				
City	State	Zip Code		
Phone				
Enrollee's Plan ID Number				
Complete the following section ONLY if the person making this request is not the enrollee:				
Requestor's Name				
Requestor's Relationship to Enrollee				
Address				
City	State	Zip Code		
Phone				
Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:				
Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.				
Prescription drug you are requesting:				
Name of drug:	Strength/c	quantity/dose:		
Have you purchased the drug pending appeal? $\Box$ Yes $\Box$ No				
If "Yes": Date purchased: receipt)	Amount paid:	: \$ (attach copy of		
Name and telephone number of pha	2			

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Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	F	ax
Office Contact Person		

## Important Note: Expedited Decisions

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 will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

## □ 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.

**Please explain your reasons for appealing.** Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

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

\_\_\_\_\_ Date: