REQUEST FOR REDETERMINATION OF MEDICARE PRESCRIPTION DRUG DENIAL

Because we EmblemHealth 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.

For Standard Appeals, you may call 1-877-444-7097 or this form may be sent to us by mail or fax:

Address: PO Box 2807, New York, NY 10116  
Fax Number: 1-866-854-2763

For Expedited Appeals, this form may be faxed to: 1-866-350-2168

You may also ask us for an appeal through our website at www.emblemhealth.com/medicare. Expedited appeal requests can be made by phone at 1-888-447-6855.

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.

<table>
<thead>
<tr>
<th>Enrollee’s Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Name:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Enrollee’s Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State</td>
</tr>
<tr>
<td>Phone:</td>
<td>Enrollee’s Plan ID Number:</td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee:

<table>
<thead>
<tr>
<th>Requestor’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Requestor’s Relationship to Enrollee:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State</td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
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</tbody>
</table>

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/quantity/dose:  

Have you purchased the drug pending appeal?  
☐ Yes  ☐ No  
If “Yes”:  
Date purchased:  
Amount paid: $  (attach copy of receipt)  

Name and telephone number of pharmacy:  

**Prescriber's Information:**  

Name:  
Address:  
City:  
State:  
Zip Code:  
Office Phone:  
Fax:  
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. The quickest way for us to get your expedited appeal is to call or fax your expedited appeal request.  

☐ 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:
HIP Health Plan of New York (HIP) is a HMO plan and Group Health Incorporated (GHI) is a PPO plan with a Medicare contract. Enrollment in HIP and GHI depends on contract renewal. HIP and GHI are EmblemHealth companies.