# REQUEST FOR REDETERMINATION OF MEDICARE PRESCRIPTION DRUG DENIAL

Because we EmblemHealth Medicare PDP 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:
Express Scripts, Inc.,
ATTN: Pharmacy Appeals – Part D
PO BOX 66588
ST. LOUIS, MO 63166-6588

Fax Number:
**1-877-852-4070**

You may also ask us for an appeal through our website at **http://www.emblemhealth.com/Our-Plans/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.

| **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:<br>Strength/quantity/dose: | | |
| Have you purchased the drug pending appeal? ☐ Yes ☐ No If "Yes":<br>Date purchased:<br>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.

☐**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.

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