Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, you have the right to ask for an independent review of the plan's decision. **You may use this form to request an independent review of your drug plan's decision**. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Please complete this form and mail or fax it to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 703
Pittsford, NY 14534-1302
Toll Free Fax: (866) 825-9507

Note about Representatives: Your prescriber may file a reconsideration request on your behalf without being an appointed representative. If you want another individual, such as a family member or friend to request an independent review for you, that individual must be appointed as your representative.

Enrollee Information:

Enrollee Name: _____

Address: _____

City, State, Zip code: _____

Phone: (_____) _____

Medicare Health Insurance Claim # _____
(From red, white and blue Medicare card)

Date of Birth (MM/DD/YYYY)**:** _____

Name of current Part D Drug Plan: _____

Complete the following section ONLY if the person making this request is not the enrollee or the enrollee's prescriber (make sure to attach documentation showing the person's authority to represent enrollee for purposes of this request):

Representative's Name _____

Representative's Relationship to Enrollee_____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____

Prescription drug you asked your plan to cover:

_____

_____

Representation documentation for appeal request made by someone other than enrollee or prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of the enrollee without being an appointed representative.

Prescribing Physician's or Other Prescriber's Information:

Prescriber Name: _____

Office Address: _____

City, State, Zip code: _____

Office Phone: (_____) _____

Office Fax: (_____) _____

Office Contact Person: _____

Expedited Decisions

If you or your prescribing physician or other prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

☐ Check this box if you believe you need a decision within 72 hours (if you have a supporting statement from your prescribing physician or other prescriber, attach it to this request)

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records.

Additional information we should consider: _____

_____

_____

Important: Please include a copy of the Redetermination (denial) Notice you received from your drug plan with this request.

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

_____ **Date:** _____