

## **Model Form Instructions Request for a Medicare Prescription Drug Redetermination**

### **Purpose of Model Form**

This model form was developed as part of the implementation of the Affordable Care Act, which requires the use of a uniform exceptions and appeals process in Part D. Related CMS regulations finalized in 2011 require Part D plan sponsors to make available a uniform model form used to request a redetermination (appeal) to the extent such form has been approved for use by CMS. This form is intended to provide basic information to enrollees and prescribers on how to ask for a redetermination from a Medicare drug plan.

Under the Medicare Part D prescription drug benefit program, a Part D plan enrollee can request a redetermination within 60 days of a plan sponsors' adverse coverage determination. A request can also be made on behalf of the enrollee by the enrollee's appointed representative or the enrollee's prescribing physician. A request for a standard redetermination is generally made in writing, but a plan can choose to accept oral requests. A request for an expedited redetermination can be made orally or in writing. **An enrollee, the enrollee's representative, or the enrollee's prescribing physician may submit a written request for a redetermination in any format.**

### **Use of Model Form**

**Plan sponsors must include a copy of this model form with all Notices of Denial of Medicare Prescription Drug Coverage.**

Use of this model form by an enrollee, representative or prescriber is **optional**. Plan sponsors must accept any written request for an appeal, including any request submitted on this model form. **If this model form is used, the Medicare drug plan may require additional information or documentation to support the request.**

**Use of this model form is optional and its content may be changed.**

## Request for Redetermination of Medicare Prescription Drug Denial

Because Longevity Health Plan 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: PO Box 5850  
Glen Allen, VA 23058-5850

Fax Number: (844) 268-9791

You may also ask us for an appeal through our website at [LongevityHealthPlan.com](http://LongevityHealthPlan.com). Expedited appeal requests can be made by phone at 1-888-886-9770, TTY 711 for Illinois residents or (888) 885-7337, TTY 711 for New York residents.

**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 Member 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/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.

**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:**