Request for Redetermination of Medicare Prescription Drug Denial

Because we Scott and White 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: Fax Number:

 1206 West Campus Drive 254-298-3086

 Temple, TX 76502

You may also ask us for an appeal through our website at www.advantage.swhp.org.

Expedited appeal requests can be made by phone at 1-866-334-3141.

**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 ☐ NoIf “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.

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