# IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

## There Are Two Kinds of Appeals You Can Request

### Expedited (72 hours)

You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

### Standard (7 days)

You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

## When the Independent Reviewer Can Extend the Timeframe for Making a Decision

The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

## How Do I Request an Appeal?

You, your prescriber, or your representative should mail or fax your written appeal request to:

MAXIMUS Federal Services
Medicare Part D QIC
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302
Fax: 1-866-825-9507

## What Do I Include with My Appeal?

You should include your name, address, member ID number, the reasons for appealing, and any evidence you wish to attach. If the appeal is made by someone other than you or your doctor or other prescriber, the person must submit a document appointing him or her to act for you.
If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug, or would harm your health.

## What Happens Next?

If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least $130. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

**If You Need Information or Help call us at:**
Toll Free: 1-844-637-4760
TTY: 711

**Other Resources To Help You**
Medicare Rights Center
Toll Free: 1-888-HMO-9050 (1-888-466-9050)

Elder Care Locator
Toll Free: 1-800-677-1116

1-800-MEDICARE (1-800-633-4227)

Plan Name: Great Plains Medicare Advantage Contract ID: H8967

Formulary ID: 00020277 *or* 00020297 Plan ID: 001 *or* 002

# 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 Beneficiary Identifier #** _____
(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. Please have your prescriber address the Plan's coverage criteria as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Additional information we should consider: _____

_____

_____

**Important: Please include a copy of the Redetermination (denial) Notice that you should have received from your drug plan if available.**

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

_____ **Date:** _____