

Request for Redetermination of Medicare Prescription Drug Denial

CareSource® MyCare Ohio (HMO D-SNP) 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. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at express-scripts.com.
- Expedited appeal requests can be made by phone at 1-800-935-6103 (TTY: 1-800-716-3231).

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at **1-855-475-3163** (TTY: **1-833-711-4711** or **711**) to learn how to name a representative.

Plan enrollee information

Enrollee name: _____
Member ID Number: _____ Date of birth (MM/DD/YYYY): _____
Mailing address: _____
City, State, ZIP code: _____
Phone: _____

Prescription & prescriber information

Name of drug you asked for: _____
Strength/quantity/dose: _____
Prescriber name: _____
Office address: _____
City, State, ZIP code: _____
Office phone: _____ Office fax: _____
Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: _____ Amount paid: _____ (attach copy of receipt)

Pharmacy name: _____

Pharmacy phone number: _____

Do you need an expedited (fast) decision?

☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider:

Representative information

Complete this section **ONLY** if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**.

Representative name: _____

Relationship to enrollee: _____

Street address: _____

City, State, ZIP code: _____

Phone: _____

Sign & submit this form

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

Signature: _____ **Date:** _____

**Fax or mail your completed form and any supporting information
to:**

Address:
Express Scripts
Attn: Medicare Appeals
P. O. Box 66588
St. Louis, MO 63166-6588

Fax Number:
1-877-852-4070

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