Request for Redetermination of Medicare Prescription Drug Denial

HAP CareSource™ MI Health Link (Medicare-Medicaid 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 an appeal. You can send this to us by mail or fax:

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

Fax Number:
1-877-852-4070

You may also ask us for an appeal through our website at Express-Scripts.com. You can ask for an expedited appeal by phone at 1-800-935-6103, (TTY users can call 1-800-716-3231 or 711), 24 hours a day, 7 days a week.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. You can ask another person (such as a family member or friend) to ask for an appeal for you. That person must be your representative. Call 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 _____

<u>If you are not the enrollee:</u> 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 made at the coverage determination level. To learn more on naming a representative, call 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 Notes: Expedited Decisions

- If you or your prescriber believes 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 shows that waiting 7 days could seriously harm your health, we will give you a decision within 72 hours.
- If you do not get your prescriber's support for a fast appeal, we will decide if your case needs a fast decision.
- You cannot ask for 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**

Attach any supporting information from your prescriber. Please explain your reasons for appealing. Attach more pages if you need to. Attach any other information you believe may help your case. This might be a statement from your prescriber and/or related medical records. You may want to refer to the explanation we give in the Notice of Denial of Medicare Prescription Drug Coverage. You may want to have your prescriber address the Plan's coverage criteria. They can find this in the Plan's denial letter or in other Plan documents. Your prescriber will need to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically right for you.

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

Date: _____

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HAP CareSource™ MI Health Link (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.