

Request for Redetermination of Medicare Prescription Drug Denial

Because we (PrimeWest Health) 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:
Clinical Review Department	1-800-693-6703 (toll free)
PrimeWest Health	
1305 Corporate Center Dr	
Eagan, MN 55121	

You may also ask us for an Appeal through our website at www.primewest.org. Expedited Appeal requests can be made by phone at **1-800-366-2906** (toll free), 7 days a week, 8 a.m. – 8 p.m. TTY users call **1-800-627-3529** or **711** (toll free).

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 Plan 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*.

Signature of person requesting the Appeal (the enrollee, or the enrollee's prescriber or representative):

_____ **Date:** _____

This information is available in other forms to people with disabilities by calling:

TOLL FREE
Member Services: 1-800-366-2906

TOLL FREE MINNESOTA RELAY
TTY, Voice, ASCII, or Hearing Carry Over: 1-800-627-3529 or 711

TOLL FREE SPEECH-TO-SPEECH RELAY SERVICE
1-877-627-3848

Member Services 1-800-366-2906

Attention. If you want free help translating this information, call the above number.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການເປ່ຍຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທລະຕາມເລກໂທລະທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

PrimeWest Health will enroll all eligible people who select or are assigned to PrimeWest Health without regard to physical or mental condition, health status, need for health care services, claims experience, medical history, genetic information, disability, marital status, age, gender, sexual orientation, national origin, race, ethnicity, color, religion, political beliefs, or geographic location. PrimeWest Health will not use any policy or practice that discriminates based on such.

American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older, this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.