



## Request for Redetermination of Medicare Prescription Drug Denial

Because we, Experience 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:

Experience Health Part D Appeals  
P.O. Box 1291  
Durham, NC 27702-1291

Fax Number:  
1-888-375-8836

You may also ask us for an appeal through our website at [experiencehealthNC.com](http://experiencehealthNC.com). Expedited appeal requests can be made by phone at 1-833-777-7394 (TTY: 711).

**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 and have your prescriber address the Plan's coverage criteria, if available, 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. \_\_\_\_\_

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

**Date:** \_\_\_\_\_

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-777-7394 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llámenos al 1-833-777-7394 (TTY: 711). Alguien que hable inglés le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的口译服务，帮助您解答关于我们健康或药物计划的任何疑问。要获得口译员服务，请致电 1-833-777-7394 (TTY: 711)。会有讲英文/中文的工作人员帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康保險或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-777-7394 (TTY: 711) 聯絡我們。我們講英語/您的語言的人員將樂意為您提供幫助。這項服務是免費的。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-777-7394 (TTY: 711). Maaari kayong tulungan ng isang nakapakagsalita ng English o Tagalog. Ito ay libreng serbisyo.

**French:** Nous fournissons gratuitement les services d'un interprète pour répondre à toutes les questions que vous pouvez avoir sur notre régime d'assurance maladie ou de médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-777-7394 (TTY: 711). Un interlocuteur qui parle anglais/français peut vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về kế hoạch sức khỏe hoặc thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-777-7394 (TTY: 711) sẽ có nhân viên nói tiếng Anh/Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelpflicht. Die Dolmetscher erreichen Sie unter 1-833-777-7394 (TTY: 711). Man wird Ihnen dort auf Deutsch oder Englisch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 처방약 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-777-7394 (TTY: 711) 번으로 문의해 주십시오. 영어/한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно плана медицинского страхования или плана получения лекарств, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-777-7394 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-английски или на вашем языке. Данная услуга бесплатная.

**Arabic:** يمكننا تقديم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطة الصحة أو الأدوية الخاصة بنا. وللحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على رقم 1-833-777-7394 (TTY: 711). وسوف يساعدك شخص يتحدث اللغة الإنجليزية / العربية. هذه خدمة مجانية.

**Hindi:** हमारी स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का जवाब देने के लिए हमारे पास मुफ्त में दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-777-7394 (TTY: 711) पर फोन करें। अंग्रेजी/हिन्दी बोलने वाला व्यक्ति आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

## Multi-language Interpreter Services

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-777-7394 (TTY: 711). Un nostro incaricato che parla inglese/italiano vi fornirà l'assistenza necessaria. Il servizio è gratuito.

**Português:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que você tiver acerca de nosso plano de saúde ou de medicação. Para obter um intérprete, contate-nos pelo número 1-833-777-7394 (TTY: 711). Você encontrará alguém que fale o idioma inglês ou português para ajudá-lo. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan asirans maladi oswa asirans medikaman nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-777-7394 (TTY: 711). Yon moun ki pale Anglè/Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza należy zadzwonić pod numer 1-833-777-7394 (TTY: 711). Osoba znająca polski i angielski udzieli Państwu pomocy. Usługa ta jest bezpłatna.

**Japanese:** 弊社の健康保険または処方薬保険に関するあらゆるご質問にお答えするために、無料の通訳サービスをご用意しております。通訳をご希望の場合は、1-833-777-7394 (TTY: 711) までお電話ください。日本語または英語を話す担当の者が支援いたします。これは無料のサービスです。