Request for Redetermination of Medicare Prescription Drug Denial

Because we, Members Health Insurance Company, 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:
Members Health Insurance Company
Prior Authorization Department
c/o Appeal Coordinator
P.O. Box 2975
Mission, KS 66201

Fax Number:
877-239-4565

You may find information regarding our appeals process on our website at www.mhinsurance.com/part-d. To ask for information about the appeals process or to learn how to file an Expedited Appeal visit our website or call Member Services at 1-855-540-4744. Our hours of operation are 8 a.m. to 8 p.m. local time, 7 days a week October 1 – March 31, and April 1 – September 30 our hours are 8 a.m. to 8 p.m., Monday – Friday. Our automated phone system may answer your call on weekends and federal holidays. TTY users should call 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 appointed as your Authorized Representative. To appoint an Authorized Representative to act on your behalf you can contact Member Services to find out more information, or visit our website at www.mhinsurance.com/part-d/how-to-appoint-a-representative. There you can locate the Appointment of Representative form and mail it to us at:

Members Health Insurance Company
Attn: Appeals Department
P.O. Box 240
Columbia, TN 38402
.

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 _____

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.

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_____

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

_____**Date:** _____