



**Request for a Medicare Part D Prescription Drug Appeal
(Coverage Redetermination)**

Because HealthChoice denied your request for coverage of, or payment for, a Part D prescription drug, you have the right to ask 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 for an appeal/coverage redetermination. This form can be returned to HealthChoice by mail or fax:

Address:
OSEEGIB, Attn: Pharmacy Unit
3545 N.W. 58 Street, Suite 110
Oklahoma City, OK 73112

Fax Number:
1-405-717-8925

Expedited appeal requests can be made by phone at 1-405-717-8699 or toll-free at 1-800-865-5142. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

Who Can Make a Request for Me? Your prescriber can ask HealthChoice 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.

Member's Information

Member's Name _____ Member's ID Number _____
Member's Address _____ City _____ State _____ ZIP _____
Phone _____

Drug Information

Drug Name _____ Drug Strength _____
Reason for Appeal _____

Complete the following section ONLY if the person making this request is not the member:

Requestor's Name _____
Relationship to Member _____
Member's Address _____ City _____ State _____ ZIP _____
Phone _____

For requests made by someone other than you or your prescriber: You must attach documentation showing the authority to represent the member (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 OSEEGIB or call 1-800-Medicare.

More information about the drug you are requesting:

Have you already purchased the drug pending appeal? Yes No

If "Yes":

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

Name and telephone number of pharmacy: _____

Prescriber Information

Prescriber's Name _____

Prescriber's 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 automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we 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 member, or the member's prescriber or representative):

_____ **Date:** _____