EmblemHealth®

REQUEST FOR REDETERMINATION OF MEDICARE PRESCRIPTION DRUG DENIAL

Because we EmblemHealth 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.

For Standard Appeals, you may call 1-877-444-7097 (TTY: 711) 8 am to 8 pm seven days a week or this form may be sent to us by mail or fax:

Address: PO Box 2807, New York, NY 10116
Fax Number: 1-866-854-2763

For Expedited Appeals, this form may be faxed to: 1-866-350-2168.

You may also ask us for an appeal through our website at **www.emblemhealth.com/medicare**. Expedited appeal requests can be made by phone at 1-888-447-6855 (TTY: 711) 8 a.m. to 8 p.m. seven days a week**.**

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**. (TTY users should call **1-877-486-2048**), 24 hours a day/7 days a week.		

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. The quickest way for us to get your expedited appeal is to call or fax your expedited appeal request.

☐ **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.

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

HIP Health Plan of New York (HIP) is a HMO plan and Group Health Incorporated (GHI) is a PPO plan with a Medicare contract. Enrollment in HIP and GHI depends on contract renewal. HIP and GHI are EmblemHealth companies.