Request for Redetermination of Medicare Prescription Drug Denial

IEHP DualChoice (HMO D-SNP) denied your request for coverage of (or payment for) [name of prescription drug]. You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at ***www.iehp.org***.
- Expedited appeal requests can be made by phone at **1-877-273-IEHP (4347)**.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at **1-877-273-IEHP (4347)** to learn how to name a representative.

Plan enrollee information

Enrollee name: _____

Member ID Number:_____ Date of birth (MM/DD/YYYY): _____

Mailing address: _____

City, State, ZIP code: _____

Phone: _____

Prescription & prescriber information

Name of drug you asked for: _____

Strength/quantity/dose: _____

Prescriber name:_____

Office address: _____

City, State, ZIP code: _____

Office phone:_____ Office fax:_____

Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

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

Pharmacy name: _____

Pharmacy phone number: _____

Do you need an expedited (fast) decision?

☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: _____

  _____

Representative information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, Call us at **1-877-273-IEHP (4347)**.

Representative name: _____

Relationship to enrollee: _____

Street address: _____

City, State, ZIP code: _____

Phone: _____

Sign & submit this form

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

Signature: _____ **Date:** _____

Fax or mail your completed form and any supporting information to:

Address:	**Fax Number:**
IEHP DualChoice Grievance Department P.O. Box 1800 Rancho Cucamonga, CA 91729-1800	**(909) 890-5748**

IEHP DualChoice (HMO D-SNP) is an HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.