

## Request for Redetermination of Medicare Prescription Drug Denial

Because we Blue Cross Medicare Advantage (PPO)<sup>SM</sup> 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:  
Blue Cross Medicare Advantage<sup>SM</sup>  
Attn: Medicare D Clinical Review  
2900 Ames Crossing Road  
Eagan, MN 55121

Fax Number:  
1-800-693-6703

You may also ask us for an appeal through our website at [www.getbluetx.com/mapd](http://www.getbluetx.com/mapd). Expedited appeal requests can be made by phone at 1-877-774-8592, TTY: 711. We are open 8:00 a.m.- 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

**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 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 (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.

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

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

HMO plan in New Mexico, HMO and HMO-POS plans in Illinois, and PPO plans in Illinois, Montana, and New Mexico are provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan in Illinois provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HMO Special Needs Plan in New Mexico provided by HCSC. HMO, PPO, and Dual Care HMO Special Needs plans in Texas provided by HCSC Insurance Services Company (HISC). HMO plans in Texas provided by GHS Insurance Company (GHSIC). All HMO and PPO employer/union group plans provided by HCSC. Oklahoma PPO plans for employer and union groups only. HMO plan in Oklahoma provided by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HCSC, ILBCBSIC, HISC, GHSIC, and BlueLincs are Independent Licensees of the Blue Cross and Blue Shield Association. ILBCBSIC, GHSIC and BlueLincs are Medicare Advantage organizations with a Medicare contract. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program. HISC is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in these plans depends on contract renewal.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-877-774-8592 (TTY: 711) We are open between 8:00 a.m. and 8:00 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-774-8592 (TTY: 711). Nuestro horario es de 8:00 a.m. a 8:00 p.m., hora local, los 7 días de la semana. Si usted llama del 1 de abril al 30 de septiembre, durante los fines de semana y feriados, se usarán tecnologías alternas (por ejemplo, correo de voz).



**BlueCross BlueShield  
of Texas**

Blue Cross and Blue Shield of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Texas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator

If you believe that Blue Cross and Blue Shield of Texas has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, [Civilrightscoordinator@hcsc.net](mailto:Civilrightscoordinator@hcsc.net). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.  
Gọi số 1-877-774-8592 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-774-8592 (TTY : 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
1-877-774-8592 (TTY: 711) 번으로 전화해 주십시오.

ملحوظ: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل رقم  
(رقم هاتف الصم والبكم: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں  
(TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-774-8592 (TTY: 711).

ATTENTION Si vous parlez français des services d'aide linguistique vous sont proposés gratuitement.  
Appelez le 1-877-774-8592 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।  
1-877-774-8592 (TTY: 711) पर कॉल करें।

توجه: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بہ صورت رایگان برای شما فراهم می باشد۔ با  
(TTY : 711) 1-877-774-8592 تماس بگیرید۔

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer : 1-877-774-8592 (TTY: 711).

सुचना: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-774-8592  
(TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  
Звоните 1-877-774-8592 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-877-774-8592 (TTY: 711)  
まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການໃບການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍທໍ່ສູ້ຄ່າ, ຈຳນວນໃຫ້. ໂທສ  
1-877-774-8592 (TTY: 711).