Request for Reconsideration of Medicare Prescription Drug Denial.

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for a prescription drug you requested, you have the right to ask for an independent review of the plan's decision. **You may use this form to request an independent review of your drug plan's decision.** You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Please complete this form and mail, fax or transmit it to:

United States Postal Service (USPS):

C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
P.O. Box 44166
Jacksonville, FL 32231–4166

UPS / FedEx ONLY:

C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 1110
Jacksonville, FL 32202

Standard Appeals Fax:

Toll Free **(833) 710-0580**

Expedited Appeals Fax:

Toll Free **(833) 710-0579**

QIC Appeals Portal: **https://www.c2cinc.com/Appellant-Signup**

Note about representatives: Your prescriber may file a reconsideration request on your behalf without being an appointed representative. If you want another individual, such as a family member or friend to request an independent review for you, that individual must be appointed as your representative.

Enrollee Information:

Enrollee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Medicare Beneficiary Identifier #: _____
(From red, white and blue Medicare card)

Date of Birth (MM/DD/YYYY): _____ / _____ / _____

Name of current Part D Drug Plan: _____ Plan Number (e.g., H1234) _____

Complete the following section ONLY if the person making this request is not the enrollee or the enrollee's prescriber (make sure to attach documentation showing the person's authority to represent enrollee for purposes of this request):

Representative's Name: _____

Representative's Relationship to Enrollee: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

Prescription drug you asked your plan to cover:

Representation documentation for appeal request made by someone other than enrollee or prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of the enrollee without being an appointed representative.

Prescribing Physician's or other prescriber's information:

Prescriber Name: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Office Contact Person: _____

Expedited Decisions: If you or your prescribing physician or other prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

☐ Check this box if you believe you need a decision within 72 hours (if you have supporting statement from your prescribing physician or other prescriber, attach it to this request).

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records. Please have your prescriber address the Plan's coverage criteria 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.

Additional information we should consider:

Important: Please include a copy of the Redetermination (denial) Notice that you should have received from your drug plan if available.

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

_____ Date: _____ / _____ / _____

Select Health obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats by contacting Select Health Medicare: **855-442-9900** (TTY: **711**) / Select Health: **800-538-5038**.

ATENCIÓN: Si habla espa ol, tiene a su disposición servicios gratuitos de asistencia ling ística.

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