

PrescribaRx (PDP)
PO Box 12407
Pensacola, FL 3259

PrescribaRxSM PDP

Medicare Prescription Drug Plans

Plan Name: _____

Contract ID: _____

Formulary ID: _____

Plan ID: _____

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 or fax it to:

MAXIMUS Federal Services

Medicare Part D QIC
860 Cross Keys Office Park
Fairport, NY 14450

Fax: (585) 425-5301

Toll Free Fax: (866) 825-9507

Note about Appointed Representatives: If you want another individual, such as a family member, friend, or your doctor to request an independent review for you, that individual must be your appointed representative. Contact your Medicare drug plan to learn how to name an appointed representative.

Today's Options PPO[®], Today's Options[®] PFFS, TexanPlus[®] HMO, Generations Healthcare HMO, Today's Health[®] HMO, and Tribute HMO are Medicare-approved PPO, PFFS and HMO plans and Community CCRxSM PDP and PrescribaRxSM PDP are federally qualified Medicare Contracting Prescription Drug Plans offered by the following organizations that contract with the Federal government: The Pyramid Life Insurance Company, SelectCare Health Plans, Inc. (d/b/a TexasFirst Health Plans[®]), SelectCare of Oklahoma, Inc., GlobalHealth, Inc., SelectCare of Texas, L.L.C and American Progressive Life & Health Insurance Company of New York and Pennsylvania Life Insurance Company, members of the Universal American family of companies.

Enrollee's Information

Enrollee's Name _____ Date of Birth ___/___/___

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone () _____

Enrollee's Medicare (HIC) Number (as shown on your Medicare card) _____

The person making this request (if not the enrollee) must include the following information:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone () _____

Attach documentation that shows authority to represent enrollee, such as a completed Form CMS-1696, if it was not submitted to the plan at the coverage determination or redetermination level.

Prescription drug you asked your plan to cover: _____

Prescribing Physician's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone: () _____ Fax: () _____

Office Contact Person _____

Expedited Decisions

If you or your prescribing physician believes 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 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. If you do not obtain your physician’s support, 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 a supporting statement from your prescribing physician, attach it to this request).

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician and relevant medical records.

Additional information we should consider: _____

Important: Please include a copy of the Redetermination (denial) Notice you received from your drug plan with this request.

Enrollee’s/Requestor’s Signature: _____ **Date:** _____