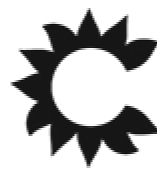

Plan Name: Community HealthFirst
Formulary ID: 00009208

Contract ID: H5826
Plan ID: ☐005; ☐ 008; ☐ 009; ☐ 010

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, Inc.
50 Square Drive, Suite 120
Victor, NY 14564
Fax: (585) 425-5301

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

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 Decision
If you or your prescribing physician 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 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:** _______________