Request for Redetermination of Medicare Prescription Drug Denial

Because we Provider Partners Maryland Advantage Plan (HMO SNP) 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:

EnvisionRx Options c/o Provider Partners
Maryland Advantage Plan
2181 E. Aurora Road, Suite 201
Twinsburg, OH 44087

Fax Number:
877-503-7231

You may also ask us for an appeal through our website at www.pphealthplan.com. Expedited appeal requests can be made by phone at 1-800-405-9681.

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.

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.

_____
_____
_____
_____
_____

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

_____ **Date:** _____