

## Request for Redetermination of Medicare Prescription Drug Denial

Because we 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:

<b>Address:</b> Appeals & Grievance Department Tufts Health Plan Medicare Preferred 705 Mt. Auburn Street Watertown, MA 02472	<b>Fax Number:</b> 1-617-673-0300
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You may also ask for an appeal through our website [tuftsmedicarepreferred.org](http://tuftsmedicarepreferred.org). Expedited appeal request can be made by phone at 1-800-701-9000 (TTY 1-800-208-9562) Monday - Friday, 8:00 a.m. - 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m - 8:00 p.m. from Oct. 15 - Feb. 14.) After hours and on holidays, please leave a message and a representative will return your call on the next business day.

**Who May Make a Request:** Your physician 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.

<b>Member's Information</b>			
Member's Name:		Date of Birth:	
Member's Address:			
City:	State:	Zip:	Phone: (     )
Member's Medicare Number (as shown on your Medicare card):			
<b>Complete the following section ONLY if the person making this request is not the member:</b>			
Requestor's Name:		Requestor's Relationship to member:	
Address:			
City:	State:	Zip:	Phone: (     )
<b><u>Representation documentation for appeal requests made by someone other than member or the member's physician:</u></b> Attach documentation showing the authority to represent the member (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 us 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 receipt):

Name and telephone number of pharmacy:

**Physician's Information**

Name:

Address:

City:

State:

Zip:

Office Phone:

( )

Fax:

( )

Office Contact Person:

**Important Note: Expedited Decisions**

If you or your physician 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 physician 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 physician'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 physician, 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 physician and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.**

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Signature of person requesting the appeal (the member, or the member's physician or representative):

Date: