TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472-1508
tuftshealthplan.com

Request for Redetermination of Medicare Prescription Drug Denial

Because we Tufts Health Plan Senior Care Options (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:	**Fax Number:**
Tufts Health Plan Senior Care Options Attn: Appeals and Grievances Dept 705 Mount Auburn Street Watertown, MA 0 2472	1-617-972-9516

You may also ask for an appeal through our website **tuftsmedicarepreferred.org/sco.** Expedited appeal requests can be made by phone at 1-855-670-5934 (TTY: 711). Representatives are available Monday – Friday, 8:00 a.m. – 8:00 p.m. (from Oct. 1 – Mar. 31, representatives are available 7 days a week from 8:00 a.m. - 8:00 p.m.).

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:		Phone: ( )
Enrollee's Plan 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:		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 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 copy of receipt):
Name and telephone number of pharmacy:	

Prescriber's Information

Name:		
Address:		
City: State: Zip:		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.

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Enrollee/Requestor/Prescriber Signature:	**Date:**

Tufts Health Plan is an HMO-SNP plan with Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in Tufts Health Plan depends on contract renewal.