P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com/Medicare

Request for Redetermination of Medicare Prescription Drug Denial

Because we CareSource Advantage Zero Premium™ (HMO), CareSource Advantage® (HMO) and CareSource Advantage Plus™ (HMO) 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:
CareSource
c/o CVS Caremark
P.O. Box 52000
MC109
Phoenix, AZ 85072-2000

Fax Number:
1-855-633-7673

*You may also ask us for an appeal through our website at **CareSource.com**.*
Expedited appeal requests can be made by phone at 1-844-607-2827 (TTY: 1-800-750-0750 or 711).

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 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 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:*** _____

CareSource is a managed care organization with a Medicare contract. Enrollment in CareSource Advantage Zero Premium, CareSource Advantage and CareSource Advantage Plus depends on contract renewal.

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

如果您或者您在帮助的人对 CareSource 存有疑问，您有权 免费获得以您的语言提供的帮助和信息。

如果您需要与一 位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

Y0119_MA-M-0253