

**Medi-CareFirst BlueCross BlueShield**  
Medicare Prescription Drug Plan Claims Center  
Pharmacy Benefits Administrator  
Dept. # 303  
P.O. Box 419019  
Kansas City, MO 64141  
Fax: 1-800-315-4025



### **Request for Redetermination of Medicare Prescription Drug Denial**

Because we, Medi-CareFirst BlueCross BlueShield, 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>  Central Appeals and Analysis Unit P.O. Box 17636 Baltimore, MD 21298-9375	<b>Fax Number:</b>  410-605-2566 or toll free: 888-415-7311
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You may also ask us for an appeal through our website at **[www.medi-carefirst.com](http://www.medi-carefirst.com)**. Expedited appeal requests can be made by phone at 1-800-693-1434 or 1-800-693-0765 (TTY) 24 hours a day, 7 days a week.

**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.

*- continued on next page -*

S5766\_RedeterminationDrugDenial12 File & Use 1/28/2012

**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.

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

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**Date:** \_\_\_\_\_