Request for Redetermination of Medicare Prescription Drug Denial

FHCP Medicare denied your request for coverage of (or payment for) ____ (name of prescription drug). You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at www.fhcpmedicare.com/contact-us.
- Expedited appeal requests can be made by phone at 1-833-866-6559 (TTY: 1-800-955-8770). Hours of operation are 8 a.m. to 8 p.m., local time, seven days a week from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, 8:00 a.m. to 8:00 p.m. local time, five days a week. We will return your call within one business day.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at 1-833-866-6559 to learn how to name a representative.

Plan enrollee information

Enrollee name: ____

Member ID Number: ______________________ Date of birth (MM/DD/YYYY): ____________________

Mailing address: ____

City, State, ZIP code: ____

Phone: ____

Prescription & prescriber information

Name of drug you asked for: ____

Strength/quantity/dose: ____

Prescriber name: ____

Office address: ____

City, State, ZIP code: ____

Office phone: ______________________ Office fax: ______________________

Office contact person: ____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: ______________________ Amount paid: ________________ (attach copy of receipt)

Pharmacy name: ____

Pharmacy phone number: ____

Do you need an expedited (fast) decision?

☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: ______________________________

____

Representative information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, Call us at 1-833-866-6559.

Representative name: ______________________________

Relationship to enrollee: ______________________________

Street address: ______________________________

City, State, ZIP code: ______________________________

Phone: ______________________________

Sign & submit this form

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

Signature: ______________________________ **Date:** ______________

Fax or mail your completed form and any supporting information to:

Address:	**Fax Number:**
FHCP Medicare Attn: Appeals & Grievances P.O. Box 9910 Daytona Beach, FL 32120	386-676-7149

HMO coverage is offered by Florida Blue Medicare, Inc., DBA FHCP Medicare, an Independent Licensee of the Blue Cross and Blue Shield Association.

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide:

- People with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language assistance services to people whose primary language is not English, which may include:
  - Qualified Interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact:

- Florida Health Care Plans (Group & Individual): 1-877-615-4022
- FHCP Medicare: 1-833-866-6559

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Health Care Plans (Group & Individual members):
Florida Health Care Plans
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com

FHCP Medicare members:
FHCP Medicare
Civil Rights Coordinator
PO Box 9910
Daytona Beach, FL 32120-0910
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Form Approved
OMB# 0938-1421

Se encuentran a su disposición los servicios gratuitos de idiomas, de ayuda auxiliar y de formato alternativo. Llame al número 1-877-615-4022, a Medicare al 1-833-866-6559, (TTY 711).

Có sẵn dịch vụ hỗ trợ ngôn ngữ miễn phí, thiết bị hỗ trợ và các định dạng thay thế. Vui lòng gọi 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Gen èd oksilyè pou ede w nan lòt lang ak sèvis nan lòt fòma ki disponib gratis. Rele nan 1-877-615-4022, oswa rele Medicare nan 1-833-866-6559 (TTY 711).

Estão disponíveis, gratuitamente, serviços de tradução, assistência e formatos alternativos. Ligue para 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

免费语言服务、辅助援助及替代格式服务均已开放。欢迎致电以下号码 普通咨询1-877-615-4022 医疗保险 （Medicare）1-833-866-6559 听障专线（TTY）711。

Des services linguistiques, d'aide auxiliaire et de supports alternatifs vous sont proposés gratuitement. Appelez le 1-877-615-4022, le Medicare au 1-833-866-6559 (ATS 711).

May makukuhang mga libreng serbisyo sa wika, karagdagang tulong at mga alternatibong anyo. Tumawag sa 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

Предоставляются бесплатные языковые услуги, вспомогательные материалы и услуги в альтернативных форматах. Звоните 1-877-615-4022, Medicare 1-833-866-6559 (номер для текст-телефонных устройств (TTY) 711).

الخدمات المجانية للغة، والمساعدة الإضافية، وتنسيقات بديلة متاحة. يرجى الاتصال على:
1-877-615-4022 برنامج Medicare: 1-833-866-6559 (لذوي الإعاقة السمعية TTY: 711)

Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Telefono: 1-877-615-4022, Medicare: 1-833-866-6559, (TTY 711).

Kostenloser Service für Sprachen, Hilfsmittel und alternative Formate verfügbar. Telefon 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711).

무료 언어, 보조 기구 및 대체 형식 서비스를 이용할 수 있습니다. 전화 1-877-615-4022, 메디케어 1-833-866-6559, (TTY 711).

Bezpłatna pomoc językowa, pomoc dodatkowa oraz usługi różnego rodzaju są dostępne. Zadzwoń pod numer 1-877-615-4022, Medicare 1-833-866-6559, (TTY 711).

મફત ભાષા, સહાયક મદદ અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.
1-877-615-4022, Medicare 1-833-866-6559, (TTY 711) પર કોલ કરો.

มีบริการภาษา ความช่วยเหลือเพิ่มเติม และบริการในรูปแบบอื่น ๆ ฟรี โทร 1-877-615-4022, Medicare 1-833-866-6559 (TTY 711)

無料の言語サービス、補助サービス、代替フォーマットサービスをご利用いただけます。1-877-615-4022、メディケア 1-833-866-6559 (TTY 711) までお電話ください。

T’áá free yíníłta’go saad bee áká anilyeedígíí, ałk’ida’áníígíí, dóó t’áá ajiłii hane’ bee áká anilyeedígíí t’éiyá éí hołne’. 1-877-615-4022 bich’į’ náhodoonih, Medicare bich’į’ 1-833-866-6559 bich’į’ náhodoonih, (TTY 711).