CarePartners of Connecticut

# 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:

| **Address:** | **Fax Number:** |
|---|---|
| Appeals & Grievance Department<br>CarePartners of Connecticut<br>705 Mt. Auburn Street<br>Watertown, MA 02472 | 1-617-972-9516 |

You may also ask for an appeal through our website carepartnersct.com. Expedited appeal request can be made by phone at 1-888-341-1507 (TTY 711). 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. 1 – Mar. 31) 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 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:<br>( ) |
| Enrollee's Medicare Number (as shown on your Medicare card): | |

## 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:<br>( ) |

**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?<br>☐ 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:<br>( ) |
| Fax:<br>( ) | 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:** |
|---|---|

CarePartners of Connecticut is an HMO plan with a Medicare contract. Enrollment in CarePartners of Connecticut depends on contract renewal.