



c/o Clinical Review  
1305 Corporate Center Dr., Building N10  
Eagan, MN 55121

### Request for Redetermination of Medicare Prescription Drug Denial

Because we Blue Cross Community MMAI (Medicare-Medicaid Plan) 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:
Blue Cross Community MMAI	1-800-693-6703
Attn: Clinical Review Department	
1305 Corporate Center Dr	
Eagan, MN 55121	

You may also ask us for an appeal through our website at <http://www.myprime.com>. Expedited appeal requests can be made by phone at **1-877-723-7702**, TTY/TDD **711**. We are available 24 hours a day, seven (7) days a week. The call is free.

**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.

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

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

If you speak Spanish, language assistance services, free of charge, are available to you. Call Member Services at **1-877-723-7702** and TTY/TDD **711**. We are available 24 hours a day, seven (7) days a week. The call is free.

Si habla español, los servicios de asistencia lingüística están a su disposición sin costo alguno para usted. Llame al **1-877-723-7702** (TTY/TDD: **711**). Estamos a su disposición las 24 horas del día, los siete (7) días de la semana. La llamada es gratuita.

Limitations and restrictions may apply. For more information, call Blue Cross Community MMAI Member Services or read the Blue Cross Community MMAI Member Handbook.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Blue Cross Community MMAI (Medicare-Medicaid Plan) is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC’s plan depends on contract renewal.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has 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: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35<sup>th</sup> floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, [Civilrightscoordinator@hsc.net](mailto:Civilrightscoordinator@hsc.net). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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>.

**English:** ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call **1-877-723-7702 (TTY/TDD: 711)**.

**Español (Spanish):** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-723-7702 (TTY/TDD: 711)**.

**繁體中文 (Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-723-7702 (TTY/TDD: 711)**。

**Tagalog (Tagalog – Filipino):** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-723-7702 (TTY/TDD: 711)**.

**Français (French):** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-723-7702 (ATS : 711)**.

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-723-7702 (TTY/TDD: 711)**.

**Deutsch (German):** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-723-7702 (TTY/TDD: 711)**.

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-723-7702 (TTY/TDD: 711)**번으로 전화해 주십시오.

**Русский (Russian):** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-723-7702 (телетайп: 711)**.

**العربية (Arabic):**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-2077-327-778 (رقم هاتف الصم والبكم: 117).

**हिंदी (Hindi):** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-723-7702 (TTY/TDD: 711)** पर कॉल करें।

**Italiano (Italian):** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-723-7702 (TTY/TDD: 711)**.

**ગુજરાતી (Gujarati):** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-723-7702 (TTY/TDD: 711)**.

**Urdu (Urdu):** کریں کال - ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو، ہیں بولتے اردو آپ اگر: خبردار **1-877-723-7702 (TTY/TDD: 711)**.

**Polski (Polish):** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-723-7702 (TTY/TDD: 711)**.

**λληνικᾶ (Greek):** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διαθέσιμη σήσας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-723-7702 (TTY/TDD: 711)**.