

## Request for Redetermination of Medicare Prescription Drug Denial

Because we, Regence Medicare Script Basic (PDP) 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:  
PO Box 12625  
MS: S5D  
Salem OR 97309

Fax Number:  
1 (866) 822-7221

You may also ask us for an appeal through our website at [www.regence.com/medicare](http://www.regence.com/medicare). Expedited appeal requests can be made by phone at 1 (800) 643-5918.

**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 complete 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: \_\_\_\_\_