Redetermination Notice of
Denial of Medicare Prescription Drug Coverage

Date: 11/09/2021

Enrollee's name: TEST CARDHOLDER
11 Wall Street
New York, NY 11111

Enrollee's ID Number: TEST4050NFTF03

Plan Name: Signature Advantage (HMO ISNP)

Contract ID: H2400

Formulary ID: 21334

Plan ID: 001

We agree with our initial coverage determination and are denying the following prescription drug(s) that you or your physician or other prescriber requested: AMBIEN 10 MG TABLET

We denied this request because: This is a test Patient Explanation.

The criterion used to make this decision was Signature Advantage (HMO ISNP) CMS approved Non Formulary Exception (NFE) Request-2 Medicare criteria. This criteria can be found in the above section of this letter under "*Please continue to read for more information and the criteria (requirements) used to make this decision*" or in the Formulary/Drug Coverage section of your prescription benefits information.

What If I Don't Agree With This Decision?

You have the right to ask for an independent review (appeal) of our decision. If your case involves an exception request and your physician or other prescriber did not already provide your plan with a statement supporting your request, **your physician or other prescriber must provide a statement to support your exception request and you should attach a copy of this statement to your appeal request.** If you want to appeal our decision, you must request your appeal in writing by mail or electronically within 60 calendar days after the date of this notice. You must submit your written request to the independent reviewer at one of the following addresses:

Standard Mail:
C2C Innovative Solutions, Inc.
P.O. Box 44166
Jacksonville, FL 32231-4166

For Mail sent by courier such as FedEx or UPS
C2C Innovative Solutions, Inc.
301 W. Bay St., Suite 600
Jacksonville, FL 32202

Fax Numbers:
For Standard Appeals: (833) 710-0580
For Expedited Appeals: (833) 710-0579

Phone: (833) 919-0198

Part D QIC Portal Address: https://www.c2cinc.com//Appellant-Signup

Who May Request an Appeal?

You, your prescriber, or someone you name to act for you (your representative) may request an appeal. If someone requests an appeal for you, he or she must send proof of his or her right to represent you with the request form. Proof could be a power of attorney, a court order, or an Appointment of Representation form. If the person appealing is your prescriber or is authorized under state law to act for you, an Appointment of Representation is not needed.

You can call us at: 833-803-4397 to learn how to name your representative. If you have a hearing or speech impairment, please call us at TTY 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours)

You can request an expedited (fast) appeal for cases that involve coverage, if you or your doctor believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days)

You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

When the Independent Reviewer Can Extend the Timeframe for Making a Decision

The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

How Do I Request an Appeal?

You, your prescriber, or your representative should mail or fax your written appeal request to:

C2C Innovative Solutions, Inc.
P.O. Box 44166
Jacksonville, FL 32231-4166
Toll Free Fax: (833) 710-0580

What Do I Include with My Appeal?

You should include your name, address, member ID number, the reasons for appealing, and any evidence you wish to attach. If the appeal is made by someone other than you or your doctor or other prescriber, the person must submit a document appointing him or her to act for you.

If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug, or would harm your health.

What Happens Next?

If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least $180. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

If You Need Information or Help call us at:
Toll Free: 844-214-8633
TTY: 711

Other Resources To Help You

Medicare Rights Center
Toll Free: 1-888-HMO-9050 (1-888-466-9050)
TTY:

Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)

Plan Name: Signature Advantage (HMO ISNP) Contract ID: H2400

Formulary ID: 21334 Plan ID: 001

Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, or upheld its decision regarding an at-risk determination made under its drug management program, you have the right to ask for an independent review of the plan's decision. **You may use this form to request an independent review of your drug plan's decision**. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. You may submit your independent review request electronically at the Part D QIC Portal address below, or you may complete this form and mail or fax it to:

Standard Mail:
C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
P.O. Box 44166
Jacksonville, FL 32231-4166

Courier or Tracked Mail (e.g. FedEx or UPS):
C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 600
Jacksonville, FL 32202

Toll Free Fax: (833) 710-0580

Web Portal Address: https://www.c2cinc.com//Appellant-Signup

Note about Representatives: Your prescriber may file a reconsideration request on your behalf without being an appointed representative. If you want another individual, such as a family member or friend, to request an independent review for you, that individual must be appointed as your representative.

Enrollee Information:

Enrollee Name: _____

Address: _____

City, State, Zip code: _____

Phone: (_____) _____

Medicare Number: _____
(From red, white and blue Medicare card)

Date of Birth (MM/DD/YYYY)**:** _____

Name of current Part D Drug Plan: _____

Complete the following section ONLY if the person making this request is not the enrollee or the enrollee's prescriber (make sure to attach documentation showing the person's authority to represent enrollee for purposes of this request):

Representative's Name _____

Representative's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____

Prescription drug you asked your plan to cover:

_____

_____

Representation documentation for appeal request made by someone other than enrollee or prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of the enrollee without being an appointed representative.

Prescribing Physician's or Other Prescriber's Information:

Prescriber Name: _____

Office Address: _____

City, State, Zip code: _____

Office Phone: (_____) _____

Office Fax: (_____) _____

Office Contact Person: _____

Expedited Decisions

If you or your prescribing physician or other prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

☐ Check this box if you believe you need a decision within 72 hours (if you have a supporting statement from your prescribing physician or other prescriber, attach it to this request)

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records. Please have your prescriber address the Plan's coverage criteria as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Additional information we should consider: _____

_____

_____

Important: Please include a copy of the Redetermination (denial) Notice that you should have received from your drug plan if available.

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

_____ **Date:** _____