



12201 Bluegrass Parkway
Louisville, KY 40299

Model Request for Reconsideration

Part D plans must include this Request for Reconsideration form with each adverse Redetermination Notice and must complete the following plan identifying information:

Plan Name: Signature Advantage (HMO ISNP)

Contract ID: H2400

Formulary ID: 20232

Plan ID: <Insert Plan ID>

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, 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. Please complete this form and mail or fax it to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 703
Pittsford, NY 14534-1302
Toll Free Fax: (866) 825-9507

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 Beneficiary Identifier # _____
(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:** _____

Disclaimers

Signature Advantage (HMO ISNP), offered by Signature Advantage, LLC., is a Health Maintenance Organization Special Needs Plan (HMO ISNP) with a Medicare contract. Enrollment in Signature Advantage depends on contract renewal.

This information is not a complete description of benefits. Call 1-844-214-8633, TTY/TDD: 711, 8:00a.m. to 8:00p.m. 7 days a week October 1 – March 31 and 8:00a.m. to 8:00p.m. Monday-Friday from April 1 – September 30 for more information.

English

Signature Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak limited English, language assistance services, free of charge, are available to you. Call 1-844-214-8633 (TTY/TDD: 711).

Español (Spanish)

Signature Advantage cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-214-8633 (TTY/TDD: 711).

Tiếng Việt (Vietnamese)

Signature Advantage tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-214-8633 (TTY/TDD: 711).