Plan Name: Signature Advantage

Contract ID: H2400

Formulary ID: 18336

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, 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:

Requests from PDP and MA-PD Plans:
MAXIMUS, Federal Services
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302

Customer Service:
Toll-free: (877) 456-5302

Fax Numbers:
Toll-free: (866) 825-9507
(585) 425-5301

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 your representative. Contact your Medicare drug plan 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 Medicare (HIC) Number (as shown on your Medicare card) _____

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):

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 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 an enrollee without being an appointed representative*.

Prescription drug you asked your plan to cover: _____

Prescribing Physician's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone: _____ 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, 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.

Additional information we should consider: _____

_____

Important: Please include a copy of the Redetermination (denial) Notice you received from your drug plan with this request.

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

_____ Date: _____

Signature Advantage is required by federal law to provide the following information.

Non-Discrimination Statement:

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. Signature Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Signature Advantage provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Signature Advantage provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Signature Advantage Customer Care Center at 1-844-214-8633. If you believe that Signature Advantage 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. If you need help filing a grievance, Customer Care is available to help you. You can file a grievance in person or by mail, fax, or email:

Signature Advantage Customer Care Center
PO Box 5850
Glen Allen, VA 23058-5850
844-214-8633
customerservice@signatureadvantageplan.com

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)

Language Assistance:

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

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 1-844-214-8633（TTY：711）。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-214-8633 (TTY: 711)

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: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-214-8633 (رقم هاتف الصم والبكم: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-214-8633 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-214-8633（TTY:711）まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-214-8633 (ATS : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-214-8633 (TTY: 711)번으로 전화해 주십시오.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-214-8633 (TTY: 711).

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-214-8633 (टिटिवाइ: 711) ।

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-214-8633 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-214-8633 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-214-8633 (TTY: 711).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-844-214-8633 (TTY: 711).