

## Request for Redetermination of Medicare Prescription Drug Denial

Wellcare denied your request for coverage of (or payment for) prescription drug. You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at [go.wellcare.com/OhanaHI](http://go.wellcare.com/OhanaHI).
- Expedited appeal requests can be made by calling Member Services at 1-888-846-4262 (TTY 711). From October 1 to March 31, you can call us 7 days a week from 7:45 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 7:45 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call Member Services at 1-888-846-4262 (TTY 711) to learn how to name a representative. From October 1 to March 31, you can call us 7 days a week from 7:45 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 7:45 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

### Plan enrollee information

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Enrollee name: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_

Mailing address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_

### Prescription & prescriber information

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Name of drug you asked for: \_\_\_\_\_

Strength/quantity/dose: \_\_\_\_\_

Prescriber name: \_\_\_\_\_

Office address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Office phone: \_\_\_\_\_ Office fax: \_\_\_\_\_

Office contact person: \_\_\_\_\_

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: \_\_\_\_\_ Amount paid: \_\_\_\_\_ (attach copy of receipt)

Pharmacy name: \_\_\_\_\_

Pharmacy phone number: \_\_\_\_\_

### **Do you need an expedited (fast) decision?**

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☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

### **Explain why you think this drug should be covered**

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- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage.
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: \_\_\_\_\_  
\_\_\_\_\_

### **Representative information**

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Complete this section **ONLY** if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, call Member Services at 1-888-846-4262 (TTY 711).

Representative name: \_\_\_\_\_

Relationship to enrollee: \_\_\_\_\_

Street address: \_\_\_\_\_

City, State, ZIP code: \_\_\_\_\_

Phone: \_\_\_\_\_

### **Sign & submit this form**

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

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

**Fax or mail your completed form and any supporting information to:**

**Address:**

Wellcare By 'Ohana Health Plan  
Pharmacy - Coverage Determinations  
P.O. Box 31397  
Tampa, FL 33631-3397

**Fax Number:**

1-866-388-1767

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.