**Request for Redetermination of Medicare Prescription Drug Denial**

Because we, Community HealthFirst™, 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: | Fax Number: |
|---|---|
| Community Health Plan of Washington | 206-613-8983 |
| ATTN: Community Health First Grievances & Appeal | |
| 1111 3rd Avenue Suite 400 | |
| Seattle, WA 98101 | |

You may also ask us for an appeal through our website at www.healthfirst.chpw.org. Expedited appeal requests can be made by phone at 1-800-942-0247, (TTY users can call 7-1-1), 8:00 a.m. to 8:00 p.m., 7 days a week.

**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 _____

**<u>Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:</u>**

**Attach documentation showing the authority to represent the enrollee (a completed 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 believes 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:** _____

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-942-0247** (TTY: **7-1-1**). Customer Service is available from 8:00am to 8:00pm, 7 days a week.