Phone **844-208-9012** (toll-free)
selecthealth.org/medicare

selecthealth ADVANTAGE

REQUEST FOR REDETERMINATION OF MEDICARE PRESCRIPTION DRUG DENIAL

Because we, SelectHealth®, denied your coverage request 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 email, fax, or mail:

> Email: **appeals@imail.org**

> Fax: **801-442-0762**

> Mail: **Attn: Appeals Department**
SelectHealth
P.O. Box 30196
Salt Lake City, UT 84130-0196

You may also ask us for an appeal through our website at **selecthealth.org/medicare**. Expedited appeal requests can be made by phone at **844-208-9012**.

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.

MEMBER INFORMATION

Member Name _____ Member ID# _____

Street Address _____ City _____ State _____

ZIP _____ Ph# (_____)_____ Email Address_____

Date of Birth _____/_____/_____

Complete the following section ONLY if the person making this request is not the member:

Requestor Name _____

Relationship to Member _____

Street Address _____ City _____ State _____

ZIP _____ Ph# (_____)_____ Email Address_____

For appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach representation 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, call SelectHealth Member Services at **855-442-9900**.

PRESCRIPTION DRUG YOU ARE REQUESTING

Name of Drug_____ Strength/Quantity/Dose _____

Have you purchased the drug pending appeal? ❑ Yes ❑ No

If "Yes," please fill out the fields below:

Date Purchased _____/_____/_____ Amount Paid_____ (Attach Copy of Receipt)

Pharmacy Name _____ Ph# (_____)_____

PRESCRIBER'S INFORMATION (THE DOCTOR WHO PRESCRIBED THE DRUG FOR YOU)

Prescriber Name _____

Street Address _____

City _____ State _____ ZIP _____

Office Ph# (_____)_____ Office Fax# (_____)_____

Office Contact Person_____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting seven 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 seven 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 an expedited 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, please attach it to this request).**

Please explain your reasons for appealing. 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

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

Signature _____ **Date** _____/_____/_____
Member or Representative

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
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