Request for Review of Plan Dismissal.

Your Medicare drug plan dismissed your request to appeal their initial decision to deny coverage or payment for a prescription drug. You have the right to ask for an independent review of the plan's decision to dismiss your appeal request. **You may use this form to request an independent review of your drug plan's dismissal**. You have 60 days from the date of the plan's Dismissal Notice to ask for an independent review. Complete this form and mail, fax or transmit itto:

United States Postal Service (USPS):

C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
P.O. Box 44166
Jacksonville, FL 32231–4166

UPS / FedEx ONLY:

C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 1110
Jacksonville, FL 32202

Toll Free Fax: **(833) 710-0580**
Web Portal Address: **https://www.c2cinc.com//Appellant-Signup**

Enrollee information:

Enrollee name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone: (________) ______________________________

Medicare Beneficiary Identifier#: ______________________________
(From red, white and blue Medicare card)

Name of current Part D Drug Plan: ______________________________

Important: If available, please include a copy of the **Dismissal Notice** that you received from your drug plan.

Reason the plan dismissed your appeal. Explain why you believe your drug plan should not have dismissed your request and include supporting information that we should consider for this review.

Note about Representatives: Your prescriber may request review 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.

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: (______) ______________________________

Representation documentation for 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 review on behalf of the enrollee without being an appointed representative.

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

______________________________ Date: ______ **/** ______ **/** ______

Select Health 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 by contacting Select Health Medicare: **855-442-9900** (TTY: **711**) / Select Health: **800-538-5038**.

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