Request for Redetermination of Medicare Prescription Drug Denial

Because CareOregon Advantage 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:
CareOregon Advantage
Attn: Pharmacy Appeals Department
315 SW Fifth Ave
Portland, OR 97204

Fax number:
(503) 416-1428

You may also ask us for an appeal through our website at www.careoregonadvantage.org. Expedited appeal requests can be made by phone at 503-416-4279 or toll-free 888-712-3258 (TTY/TDD 711).

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 _____

Phone _____

Enrollee's member 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 _____

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 _____

Office phone _____ Fax _____

Office contact person _____

Important Note: Expedited Decisions
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 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.

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

_____ Date: _____