Request for Redetermination of Medicare Prescription Drug Denial

Because we UnitedHealthcare Dual Complete (HMO SNP) 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:

UnitedHealthcare Dual Complete (HMO SNP)
1 East Washington Suite 900
Phoenix AZ 85004
Fax 877-940-5340

You may also ask us for an appeal through our website at http://www.uhccommunityplan.com/plan/state/AZ/index
Expedited appeal requests can be made by phone at 1-877-614-0623.

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 ________________________________

Representation documentation for appeal requests made by someone other than enrollee or the enrollee’s prescriber:

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.

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 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: ____________