Request for Redetermination of Medicare Prescription Drug Denial

Because we UnitedHealthcare 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
Part D Appeal and Grievance Department
PO Box 6106
Cypress, CA 90630-9948
MS: CA124-0197
Fax: (866) 308-6294

You may also ask us for an appeal through our website at www.uhccommunityplan.com. Expedited appeal requests can be made by phone at (800) 595-9532.

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.

<table>
<thead>
<tr>
<th>Enrollee’s Information</th>
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</thead>
<tbody>
<tr>
<td>Enrollee’s Name ___________________________ Date of Birth ________________</td>
</tr>
<tr>
<td>Enrollee’s Address ________________________________ ____________________________</td>
</tr>
<tr>
<td>City __________________ State ______ Zip Code __________________</td>
</tr>
<tr>
<td>Phone ___________________</td>
</tr>
<tr>
<td>Enrollee’s Plan ID Number __________________</td>
</tr>
</tbody>
</table>

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.
**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 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.

__________________________________________

__________________________________________

__________________________________________

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

__________________________________________  Date: __________________