Request for Redetermination of Medicare Prescription Drug Denial

Because we, CareSource® MyCare Ohio (Medicare-Medicaid Plan), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (a852-4070 Attn: Medicar
P.O Box 66588
St. Louis, MO 63166-6588

lso ask us for an appeal through our website at CareSource/MyCare. Expedited appeal an be made by phone at 1-855-475-3163, (TTY users can call 1-800-750-0750 or 711), Friday, 8 a.m. – 8 p.m.

Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want lividual (such as a family member or friend) to request an appeal for you, that individual ur representative. Contact us to learn how to name a representative.

nformation

Name Date of Birth

Address

State Zip Code

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 believes 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 and have your prescrou .1 (r)2.1 (iber)2 (,)-5 (ar2)-1 (o)5u have a-

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