Request for Redetermination of Medicare Prescription Drug Denial

Because we, Experience Health, 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:

Experience Health Part D Appeals
P.O. Box 17509
Winston-Salem, NC 27116-7509

Fax Number:
1-888-375-8836

You may also ask us for an appeal through our website at experiencehealthNC.com. Expedited appeal requests can be made by phone at 1-833-777-7394.

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.

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 and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you. _____

_____

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

_____ **Date:** _____

Non-Discrimination andAccessibility Notice

Experience Health (EXH) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats
  (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service
Call the number on the back of your ID card

If you believe that Experience Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Experience Health, P.O. Box 52382, Durham, NC 27717 Attention: Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office
Call: 833-777-7394 (TTY, 711)
Fax: 919-287-5613
E-mail: civilrightscoordinator@experiencehealthnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Mail:
U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Experience Health. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Contact:

Customer Service
Call the number on the back of your ID card

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Discrimination is Against the Law

Experience Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Experience Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal.

Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Services number on the back of your member ID card.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número que figura al dorso de su tarjeta de identificación.

注意：如果您講廣東話或普通話， 您可以免費獲得語言援助服務。請撥打您會員 ID 卡背面的客服部電話號碼。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng trên mặt sau thẻ thành viên ID của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객 서비스 전화번호로 전화해 주십시오

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Téléphonez le Service clients au numéro qui figure au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء الموضح على ظهر بطاقة هوية العضو الخاصة بك.

LUS CEEV:Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xovtoo ntawm Lub Chaw Pab Cuam Tswv Cuab uas nyob sab tom qab koj daim npav tswv cuab ID.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на оборотной стороне вашей карточки участника.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Serbisyo sa Kostumer sa likod ng Id kard ng miyembro.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. .તમારા સભ્યપદ ઓળખપત્રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગ્રાહક સેવાઓના નંબર પર કૉલ કરો.

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ
បសេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។សូមហៅទៅកា
ន់បសេវាអតិថិជនដោយប្រើលេខទូរស័ព្ទនៅខាងក្រោយកាតសមាជិករបស់លោកអ្នក។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Nummer des Kundenservice an, die auf der Rückseite Ihrer Mitglieds-ID-Karte angegeben ist.

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवाएं नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ທ່ານ. ໃຫ້ໂທຫາຂອງຝ່າຍບໍລິການລູກຄ້າຕາມເບີຢູ່ດ້ານຫຼັງບັດຂອງທ່ານ.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。メンバーIDカードの裏面のカスタマーサービス番号にお電話ください。

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