KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Part D Coverage Determinations	**Policy #**	13.30-P
Policy Owner	Pharmacy	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	1/22/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this document is to describe the Medicare Part D coverage determination and exceptions policy and procedures for Kern Health Systems (KHS) Pharmacy Operations staff to help ensure compliance with all applicable federal and state laws and Centers for Medicare and Medicaid Services (CMS) requirements.

II. POLICY

This is the policy of KHS that the Medicare Part D coverage determination and exceptions process adheres to specific CMS requirements to ensure the protection of Medicare beneficiary rights and establish a standard for fully addressing and responding timely to these coverage determination requests.

III. DEFINITIONS

TERMS	DEFINITIONS
Appeal	As defined at 42 Code of Federal Regulations (CFR) §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE),

	adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Appointed Representative	An individual either named by an enrollee including his/her prescribing physician or authorized under State or other applicable law to act on behalf of the enrollee. The Appointed Representative form is found on the KHS website.
Cash Purchase	A Member's purchase of a covered drug without using their KHS benefits.
CMS	The federal agency within the Department of Health and Human Services that administers the Medicare program and oversees all Medicare Advantage Organizations.
Controlled Medication	A prescription drug that is regulated by the Drug Enforcement Administration (DEA) based on its currently accepted medical use in treatment in the United States, its relative abuse potential, and its likelihood of causing dependence when abused.
Coverage Determination (CD)	Any decision (i.e., an approval or denial for a prescription drug) made by KHS or its Pharmacy Benefit Manager (PBM), regarding payment or benefits to which a member believes he or she is entitled. A. Receipt of, or payment for, a prescription drug that a Member believes may be covered; B. A tiering or Formulary Exception request; C. The amount that the plan sponsor requires a Member to pay for a Part D prescription drug and the Member disagrees with the plan sponsor; D. A limit on the quantity (or dose) of a requested drug and the Member disagrees with the requirement or dosage limitation; E. A requirement that a Member try another drug before the plan sponsor will pay for the requested drug and the Member disagrees with the requirement; F. A decision whether a Member has, or has not, satisfied a Prior Authorization or other Utilization Management requirement. Presentation of a prescription at the pharmacy counter is not a coverage determination.

Dismissal	A decision not to review a request for an initial determination because it is considered invalid or does not otherwise meet Medicare Part D requirements.
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
Effectuation	Payment of a claim, authorization or provision of a benefit KHS has approved. For the purpose of this policy, effectuate is intended to include oral and written notification to the member, written notification to the prescriber and override entry in PBM claims payment system so that a claim is paid.
Exceptions	Exceptions are types of Coverage Determinations. Requests for coverage of a non-formulary Part D covered drug, changing the tier copay ("tiering exception") or waiver of Prior Authorization requirements.
Formulary	A list of Part D drugs covered by KHS for members enrolled in its plans/ The Formulary is a continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and/or treatment of disease and promotion of health.
Independent Review Entity (IRE)	An independent entity contracted by CMS to review adverse level one (1) (redetermination) appeal decisions made by the plan.
Low Income Cost-share Subsidy (LICS)	Medicare subsidy specific to Part D for qualified beneficiaries in the form of reduced co-payments.
Member	A beneficiary enrolled in KHS.
Pharmacy Benefits Manager (PBM)	Perform Rx is KHS's PBM and provides the POS claims processing system for pharmacy claims.
Part D Drug	A drug that may be dispensed only upon a prescription, is being used for medically-accepted indication as defined by section 1927(k)(6) of the Social Security Act, and is one of the following: A. A drug that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act;

	B. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act; C. Insulin described in section 1927(k)(2)(C) of the Act; D. Medical supplies associated with the delivery of insulin; E. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
Point of Service (POS)	At the pharmacy point of service.
Prior Authorization (PA)	A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member.
Provider Supporting Statement	Reasons provided by the prescriber when a drug being requested is not on the Formulary or the prescriber requests a waiver of the UM requirements. The statement has to indicate reasons why the member cannot use a Formulary drug, a Formulary drug with no Utilization Management (UM) edits or a lower-cost sharing drug. A statement of medical justification consistent with the requirements set forth in Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).
Quantity Limits (QL)	Dose restriction, including the number and/or dosage form, that causes a particular Part D drug not to be covered for the number of doses and/or dosage form prescribed
Step Therapy (ST)	Particular Part D drug not to be covered until the requirements of the plan's coverage policy are met, which requirements are approved by CMS.
Redetermination	Level one (1) Part D appeal which reviews an adverse coverage determination, including the findings upon which the decision was based and any other submitted evidence.
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made.
Tolling	Delaying the start of and extending the timeframe of review for a standard or expedited Exception request if the plan is waiting to receive the prescriber's supporting statement. A plan may toll a request for up to fourteen (14) days. Reimbursement requests are not eligible for tolling.

Utilization Management (UM) Edits	Requirements for the approval of a drug which can be one of the following: prior authorization (PA), step therapy (ST), or a quantity limit (QL).
Withdrawal	A verbal or written request to rescind or cancel an initial determination.

IV. PROCEDURES

A. Requesting a Coverage Determination (CD)

1. When a medication with prior authorization (PA) requirements is requested through the point-of-sale (POS) system, a message is transmitted to the Pharmacy indicating that the drug is not covered. The pharmacy should notify the Member, the Member's appointed representative, the prescribing Physician or other prescriber to request a CD.

2. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may submit a CD request orally, electronically, or in writing.
    a. If the person making the request is not the Member or the Member's Prescriber, a completed Authorization of Representation Form CMS-1696 (AOR) is required.
    b. More information on how and where to contact the PBM for help with requesting CDs may be found in the Member Handbook Evidence of Coverage (EOC), which may be found on the KHS website.

3. Requests for cash reimbursements are considered CD requests. The request may be made up to one year from the date of service. See Policy 13.31-P, "Direct Member Reimbursement" for more information.

4. All CD requests should provide information that support the medical necessity or meet the criteria for prior authorization, as well as previous successful or failed therapies, any allergies, or any other clinical condition when applicable.

5. A CD request for services that have already been furnished:
    a. Will not be expedited.
    b. Will be accepted only in written formats when direct payment to the Member is also requested.

6. Standard CDs will be reviewed timely, and the Prescriber and either the Member, or the Member's Appointed Representative (if applicable), will be notified of the decision within seventy-two (72) hours of receiving the request.

B. Requesting an Expedited CD

1. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request to expedite a CD, if waiting for a standard CD may seriously jeopardize the Member's life, health, or ability to regain maximum function.

2. Requests for CDs for drugs already furnished to the Member will not be expedited.

3. A CD request will be expedited if:
    a. A request to expedite is made or supported by a Prescriber, and the Prescriber indicates, either orally or in writing, that applying the standard time for making a determination may seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.
    b. A request to expedite is made by a Member or Member's Appointed Representative and it is found that the Member's health, life, or ability to regain maximum function may be seriously jeopardized by waiting for a standard CD.

4. Expedited Coverage Determinations will be reviewed timely, and the prescriber and either the Member, or the Member's Appointed Representative (if applicable), will be notified of the decision within 24 hours of receiving the request.

5. If a request to expedite a CD is denied, it will proceed as follows:
    a. The request will be transferred and processed under the standard CD procedures as set forth in this policy.
    b. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member will be verbally notified of the denial promptly.
    c. Written notice will be provided to A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member within three calendar days after providing verbal notice.
    d. Verbal and written notifications will:
        i. Explain that the request will process within the standard CD timeframe.
        ii. Inform the Member of the right to file an expedited grievance if he or she disagrees with the decision not to expedite the CD.
        iii. Inform the Member of the right to resubmit a request for an expedited CD with the Prescriber's support.
        iv. Provide instructions about the expedited grievance process and timeframes.

C. Requesting a Tiering Exception

1. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request an Exception CD either verbally or in writing for an exception to KHS's tiered cost-sharing structure (Tiering Exception).
    a. The request will include an oral or written supporting statement from the Prescriber that the drug in the lower cost-sharing tier for treatment of the Member's condition:
        i. Would not be as effective as the requested drug in the higher cost-sharing tier;
        ii. Would have adverse effects; or
        iii. Both of the above.

2. KHS is not required to approve a Tiering Exception for a drug in a higher cost-sharing tier at the generic tier cost-sharing level as long as KHS maintains a separate tier that only includes generic drugs as defined in Title 42 of the Code of Federal Regulations.

3. Under Title 42 of the Code of Federal Regulations, Section 423.578(c)(4)(iii), a Tiering Exception may not be requested for a Non-Formulary drug approved under the Formulary Exception process.

4. A Tiering Exception will be granted if it is determined that the drug in the lower cost-sharing tier for treatment of the Member's condition would not be as effective for the Member as the requested drug and/or would have adverse effects.

D. Requesting a Formulary Exception

1. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request a Formulary Exception CD to obtain a Covered Part D Drug that is not included on KHS's Formulary.
    a. The request will include an oral or written supporting statement from the Prescriber documenting that the requested drug is medically necessary to treat the Member's disease or medical condition because all Covered Part D Drugs on any tier of the KHS Formulary for treatment of the same condition:
        i. Would not be as effective for the Member as the requested drug;
        ii. Would have adverse effects for the Member; or
        iii. Both of the above.

2. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request a Formulary Exception CD to

obtain a Covered Part D Drug that is included on KHS's Formulary and subject to a Step Therapy restriction, which the requestor believes should not apply.

a. The request will include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the prescription drug alternative(s) listed on the Formulary:

i. Has been ineffective in the treatment of the Member's disease or medical condition; or

ii. Based on sound clinical and medical and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, it is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

3. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request a Formulary Exception CD to obtain a Covered Part D Drug that is included on KHS's Formulary and subject to a Quantity Limit restriction, which the requestor believes should not apply

a. The request will include an oral or written supporting statement from the Prescriber documenting that the requested drug is Medically Necessary to treat the Member's disease or medical condition because the number of doses available under a dose restriction (Quantity Limit) for the prescription drug:

i. Has been ineffective in the treatment of the Member's disease or medical condition; or

ii. Based on sound clinical, medical, and scientific evidence, and the known relevant physical or mental characteristics of the Member, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

4. A Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member may request a Formulary Exception CD to obtain a Covered Part D Drug that is included on KHS's Formulary and subject to a Prior Authorization restriction, which the requestor believes should not apply.

a. The request will include an oral or written supporting statement from the Prescriber documenting that:

i. The requested drug is Medically Necessary to treat the Member's disease or medical condition; and

ii. The Member would suffer adverse effects if he or she were required to satisfy the PA requirement.

5. Under Title 42 of the Code of Federal Regulations, Section 423.578(f), nothing in the regulations or in this Policy should be construed to mean that the Prescriber's Supporting Statement will result in an automatic favorable determination.

6. The Formulary Exception request will be granted if it is determined that:
    a. The requested drug is medically necessary, based on the physician's or other Prescriber's supporting statement; and
    b. All Covered Part D Drugs on any tier of the Formulary for treatment of the same condition:
        i. May not be as effective for the Member as the requested drug;
        ii. May have adverse effects for the Member; or
        iii. Both of the above.

E. Requesting Retrospective Coverage and Payment Reimbursement for a Cash Purchase

1. Any decision made about reimbursing a Member for a drug and any decision to reimburse the Member for all or part of a cost-sharing amount is a CD.

2. A request for reimbursement will be made in writing by the Member, a Member's Appointed Representative, a Member's Prescribing Physician, or other Provider of health care services for the Member.

3. More information on requesting reimbursement for a cash purchase may be found in Policy 13.31-P, "Direct Member Reimbursement."

F. Request for CD for Medicare Part B versus Medicare Part D Drugs

1. KHS will not consider a drug prescribed to a Member a Covered Part D Drug if payment for such drug is available (or would be available but for the application of a deductible) under Medicare Part A or Medicare Part B for that Member.

G. Time Frames for Completing CDs

1. Standard Prospective Request
    a. Standard CD requests will be completed timely.
    b. KHS and/or its PBM will notify the Member or Member's Appointed Representative and the Prescribing Physician or other Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than seventy-two hours after the date and time that the request is received, or if the request

involves a Formulary or Tiering Exception, the date and time the Prescriber's Supporting Statement is received.

2. Expedited Prospective Request
    a. Expedited CD requests will be completed timely.
    b. KHS and/or its PBM will notify the Member or Member's Appointed Representative and the Prescribing Physician or other Prescriber, and effectuate the decision, if applicable, as expeditiously as the Member's health condition requires, but no later than twenty-four hours after the date and time that the request is received, or if the request involves a Formulary or Tiering Exception, the date and time that the Prescriber's Supporting Statement is received.

3. Retrospective Request
    a. Requests for reimbursement for covered Part D drugs that were already furnished to the Member may not be expedited.
    b. For a retrospective request involving direct payment to the Member, KHS will complete the CD, notify the Member or Member's Appointed Representative and the Prescriber, and effectuate the decision, if applicable, no later than 14 calendar days after the date and time request was received.

4. Time Frame Extension
    a. Tolling a Medicare Part D Request for a Formulary or Tiering Exception
        i. The timeframe for review of a standard or expedited Formulary or Tiering Exception CD request may be extended, or tolled, if the Prescriber does not submit a supporting statement for the medical necessity of the requested drug.
        ii. For standard and expedited prospective Exception requests, the Exception request may be tolled for up to fourteen (14) calendar days, and a decision will be made within twenty-four (24) hours from the end of the Tolling period with the best available information.
        iii. KHS will provide written notification to the Member when a Part D Exception request is tolled to obtain a Prescriber Supporting Statement.
        iv. Tolling will not apply for Non-Exception requests.
        v. Tolling will not apply for retrospective payment requests.

5. Effect of Failure to Meet the Timeframe for an Initial Determination
    a. If a decision is not made, or notice of the decision is not provided in the applicable timeframe, then within twenty-four (24) hours of the expiration of the adjudication time:
        i. The request and complete case file will be forwarded to the Independent

Review Entity (IRE) for review.

ii. The Member, or the Member's Appointed Representative, will be notified that the decision was not made timely and that their request is being forwarded to the IRE.

b. If the decision was fully favorable and was made within 24 hours after the expiration of the adjudication timeframe, the request and case file will not be forward to the IRE. The decision will be effectuated and the Member, or Member's Appointed Representative, will be notified of the favorable decision.

H. Request for Additional Information

1. When all the information needed to make a coverage decision is not submitted with the initial CD request, a reasonable and diligent effort to obtain all necessary information, including medical records and other pertinent documentation, from the Member's Prescriber will be made.

2. A minimum of one attempt to obtain additional information within the applicable adjudication time frame will be made; however, when possible, multiple attempts and/or means of communication will be utilized:
    a. Telephone.
    b. Fax.
    c. E-mail.
    d. Standard or overnight mail with certified return receipt.

3. All attempts to obtain additional information will be documented and maintained in the case file.

I. Notification Standards

1. Written notification is required for fully favorable decisions pertaining to Medicare Part D benefits. The notification will be written in a manner that is understandable to the Member and explain the conditions of the approval.

2. Written notification is required for all unfavorable decisions (fully or partially unfavorable) pertaining to Medicare Part D. The notification will be specific to each individual case and written in a manner that is understandable to the Member. It will include:
    a. The specific reason for the denial.
        i. This will take into account the Member's presenting medical condition, disabilities, and special language requirements, if any.
    b. A description of the criteria used to make the decision.

i. Any applicable Medicare coverage rule or any other applicable Part D plan policy upon which the denial decision was based, including the type of information that should be submitted when seeking a Formulary or Tiering Exception, if applicable.

c. Procedures for obtaining additional information about criteria used in the review process.

d. Information regarding the right to appoint a representative to file an Appeal on the Member's behalf.

e. A description of the standard and expedited Redetermination processes and timeframes.

3. The initial notification may be given orally, so long as a written follow-up decision is mailed within three calendar days of the oral notification. Oral notifications must satisfy the same content requirements as written notifications.

4. When the Member's telephone number and/or mailing address is invalid or missing, KHS, or its downstream delegated entities, will make a reasonable and diligent effort to obtain it. Any outreach efforts will be documented and maintained in the case file.

J. Delegated Oversight

1. KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS guidelines and regulations. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	Form 1696 – Appointment of Representative Form
Attachment B:	Notice of Approval
Attachment C:	Notice of Denial Part D Prescription Drug Coverage_Form CMS-10146
Attachment D:	Notice of Denial Part D Prescription Drug Coverage Spanish_Form CMS-10146
Attachment E:	Notice of Partial Denial Part D Prescription Drug Coverage_Form CMS-10146
Attachment F:	Notice of Partial Denial Part D Prescription Drug Coverage Spanish Form CMS-10146
Attachment G:	Notice of PA Not Required
Attachment H:	Notice of Request for Records/Additional Information

Attachment I:	Notice of Case Status

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	42 CFR §423.560
Regulatory	Title 42 of the Code of Federal Regulations, Section 423.578(b)(5).
Regulatory	Part C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - Section 50 (11.18.2024)
Regulatory	Part C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - Section 60 (11.18.2024)
Regulatory	Part C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - Sections 70, 80 and 90, and Appendix 2 (11.18.2024)
Other KHS Policies	13.31-P, Direct Member Reimbursement

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	10/30/2025	Definition of Prior Authorization	B.W Pharmacy
Revised	10/24/2025	Revised 'Prior Authorization' definition in the definitions table	Pharmacy/UM
Effective	01/01/2026	New Policy created to comply with D-SNP	M.C Pharmacy

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Form Approved
OMB No. 0938-0950
Expires: 08/31/2025

Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier
Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -
Signature	Date signed (mm/dd/yyyy) / /

Section 2: Information about the representative

This section must be completed by the representative.

Representative name

Professional status or relationship to the person in Section 1 (attorney, relative, etc.)

Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

Signature	Date signed (mm/dd/yyyy) / /

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) / /

Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.

Signature	Date signed (mm/dd/yyyy) / /

Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked "optional." If the person or entity appointing a representative doesn't have a Medicare number or National Provider Identifier, fill in "not applicable." Go to the regulation at 42 CFR 405.910: **ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910**

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it's valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court), is required to have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed representative, and the court approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: **HHS.gov/sites/default/files/OMHA-118.pdf**

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE for more information.

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

*****BANNER PAGE*****

Page intentionally added for your privacy.

DECISION_DATE

MBR_FIRST_NAME1 MBR_LAST_NAME1
MBR_LINE1_ADDR1
MBR_LINE2_ADDR1
MBR_CITY1, MBR_STATE1 MBR_POSTAL_CODE1

Dr. PHY_FIRST_NAME PHY_LAST_NAME
FN_PHY_FAX

RE: MBR_FIRST_NAME2 MBR_LAST_NAME2
Member ID: MBR_MEMBER_NO
Prior Authorization Reference Number: PA_NUMBER
CMS Plan Name: PLAN_NAME1
Plan Type: CMS_PLAN_TYPE
Plan Code: CARRIERHQCODE

Dear MBR_FIRST_NAME3 MBR_LAST_NAME3,

This is to advise you that your request for FN_DRUG_SMRT_LABEL on MRF_RECV_DATE has been approved. APPROVAL_LENGTH_STR

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

This approval may be subject to plan coverage limitations as defined in the member's benefit.

If you have any questions or comments regarding this decision, please contact MedImpact at HELP_PHONE. Our call center is open 24 hours a day, 365 days a year. TTY users should call 711.

Sincerely,

Prior Authorization Department

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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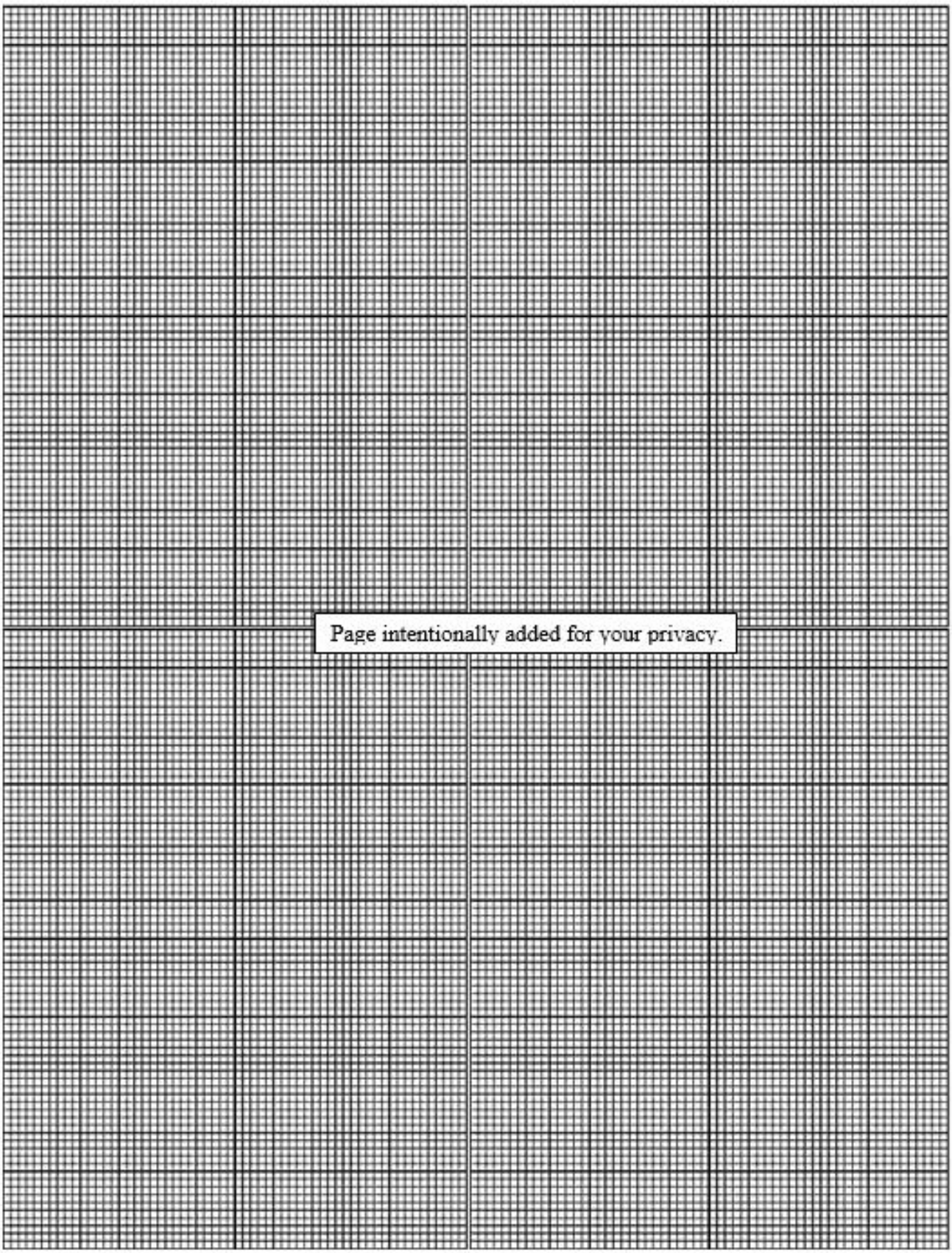
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS
FOR MEDICARE & MEDICAID SERVICES

10181 Scripps Gateway Ct., San Diego, CA 92131
1-800-788-2949

Notice of Denial of Medicare Part D Drug Coverage

Date: DECISION_DATE

Enrollee Name: MBR_FIRST_NAME1 MBR_LAST_NAME1

Member Number: MBR_MEMBER_NO

Coverage of your drug was denied

We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for: FN_DRUG_SMRT_LABEL

Why was coverage for this drug denied?

We denied coverage for this drug because:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

Share this notice with your prescribing provider and discuss next steps. If your prescribing provider asked for coverage for this drug on your behalf, we already shared this denial notice with them.

You have the right to appeal this decision

You have the right to ask us to review our decision by asking us for an appeal within 65 calendar days of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late.

You or your prescribing provider have the right to ask us for a special type of appeal called an **"exception."** Your prescribing provider must provide a statement to support your exception request. Examples of an exception are:

- **Formulary exception:** you need a drug that's not on our list of our covered drugs (formulary).
- **Coverage rule exception:** you think a coverage rule (like prior authorization or a quantity limit) shouldn't apply to you for medical reasons.
- **Tiering Exception:** you need to take a non-preferred drug that's on a higher cost-sharing tier, and you want our plan to cover the drug at a lower cost-sharing amount.

Who can ask for an appeal?

You, your prescribing provider, or your representative can ask for an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative. To learn how to appoint a representative, call us at: PLAN_APPEAL_PHONE. TTY users call: PLAN_APPEAL_TTY.

Important Information About Your Appeal Rights

There are 2 kinds of appeals: standard or expedited (fast)

Standard appeal: you'll get a written decision within 7 days (or 14 days if your appeal is about a payment for a drug you already received).

Expedited appeal (fast): you'll get a written decision within 72 hours.

- You can ask for an expedited (fast) appeal when you or your prescribing provider believe that your health could be seriously harmed by waiting for a standard decision.
- You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already received.
- We'll automatically expedite your appeal if your prescribing provider asks for one for you (or supports your request) and indicates that waiting for a standard decision could seriously harm your health. If you ask for an expedited appeal without support from your prescribing provider, we'll decide if your health requires an expedited appeal. If we don't give you an expedited appeal, we'll process a standard appeal.

How to ask for an appeal

For an **expedited** (fast) appeal, phone is the fastest way to ask:

Phone: PLAN_APPEAL_PHONE1 TTY: PLAN_APPEAL_TTY1

For a **standard** appeal: You can file an appeal by phone, by fax, online, or by mailing a letter to the address below.

Phone: PLAN_APPEAL_PHONE2

TTY: PLAN_APPEAL_TTY2

Fax: PLAN_APPEAL_FAX

Plan Website: PLAN_APPEAL_WEB

Address: PLAN_APPL_ORG
PLAN_APPL_ATTN
PLAN_APPL_ADDR1
PLAN_APPL_ADDR2
PLAN_APPL_CITY, PLAN_APPL_STATE PLAN_APPEAL_ZIP

What to include with your appeal request

- Your name, address and member number
- The reasons you're appealing
- Any evidence you want to attach to support your case
- Supporting statement from your prescribing provider

What happens next

After you appeal, we'll review your case and give you a decision. If any of the drugs you asked for are still denied, you can ask for the next level of appeal, which is an independent review of your case by a reviewer outside of our plan. If you disagree with that decision, you'll have the right to further appeal. You'll be notified of your appeal rights if this happens.

Get help & more information

- **PLAN_NAME1** Toll Free: PLAN_APPEAL_PHONE3
  TTY users call: PLAN_APPEAL_TTY3
  PLAN_APPEAL_HRS
  PLAN_APPEAL_WEB1
- **1-800-MEDICARE** (1-800-633-4227), TTY users call: 1-877-486-2048
- **Medicare Rights Center:** 1-888-HMO-9050 (1-888-466-9050)
- **Elder Care Locator:** 1-800-677-1116 or Eldercare.acl.gov/Public/Index.aspx to find help in your community
- **State Health Insurance Program:** call your State Health Insurance Assistance Program for free, personalized health insurance counseling. Visit SHIPhelp.org or call 1-877-839-2675 to get the number for your local SHIP.

Get information in another format
You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0976. This information collection is for the notice Medicare drug plans must provide when a request for a drug is denied in whole or in part. The time required to complete this information collection is estimated to average less than 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1860D-4(g)(h) of the Act and the regulatory authority set in Subpart M of Part 423 at 42 CFR 423.568 and 423.572. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Request for Redetermination of Medicare Prescription Drug Denial

PLAN_NAME4 denied your request for coverage of (or payment for) FN_DRUG_SMRT_LABEL1. You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at PLAN_APPEAL_WEB3.
- Expedited appeal requests can be made by phone at PLAN_APPEAL_PHONE6.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at PLAN_APPEAL_PHONE7 to learn how to name a representative.

Plan enrollee information

Enrollee name: _____

Member ID Number: _____ Date of birth (MM/DD/YYYY): _____

Mailing address: _____

City, State, ZIP code: _____

Phone: _____

Prescription & prescriber information

Name of drug you asked for: _____

Strength/quantity/dose: _____

Prescriber name: _____

Office address: _____

City, State, ZIP code: _____

Office phone: _____ Office fax: _____

Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: _____ Amount paid: _____ (attach copy of receipt)

Pharmacy name: _____

Pharmacy phone number: _____

Do you need an expedited (fast) decision?

☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: _____
  _____

Representative information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, Call us at PLAN_APPEAL_PHONE8.

Representative name: _____

Relationship to enrollee: _____

Street address: _____

City, State, ZIP code: _____

Phone: _____

Sign & submit this form

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

Signature: _____ **Date:** _____

Fax or mail your completed form and any supporting information to:

Address: PLAN_APPL_ORG3
PLAN_APPL_ADDR13
PLAN_APPL_ADDR23
PLAN_APPL_CITY3, PLAN_APPL_STATE3
PLAN_APPEAL_ZIP3

Fax Number: PLAN_APPEAL_FAX3

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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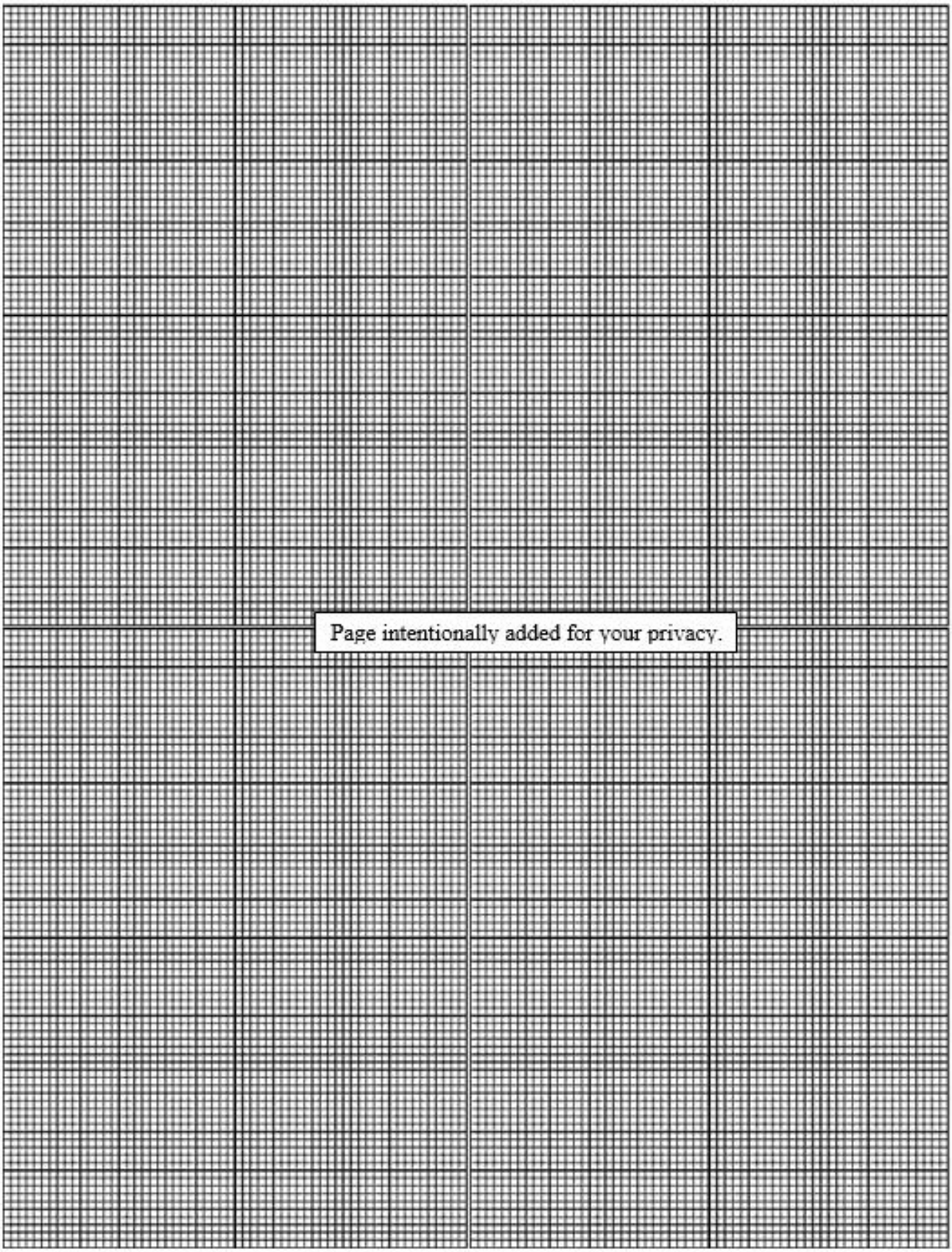
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DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS
CENTROS DE SERVICIOS DE MEDICARE Y MEDICAID

10181 Scripps Gateway Ct., San Diego, CA 92131
1-800-788-2949

Aviso de denegación de la cobertura de medicamentos de la Parte D de Medicare

Fecha: DECISION_DATE

Nombre del afiliado: MBR_FIRST_NAME1 MBR_LAST_NAME1

Número de afiliado: MBR_MEMBER_NO

Se denegó la cobertura de su medicamento

Hemos denegado la cobertura en virtud de la Parte D de Medicare para los siguientes medicamentos recetados que usted o el profesional que le receta solicitó:
FN_DRUG_SMRT_LABEL

¿Por qué se denegó la cobertura para este medicamento?

Denegamos la cobertura para este medicamento debido a:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

Debe compartir este aviso con el profesional que le receta y analizar los pasos siguientes. Si el profesional que le receta solicitó cobertura para este medicamento en su nombre, ya compartimos esta negativa con él.

Usted tiene derecho a apelar esta decisión

Si desea hacerlo, tiene que solicitarnos una apelación en el plazo de 65 días calendario desde la fecha de este aviso. Si solicita una apelación después de transcurridos 65 días, deberá explicar por qué su apelación llega tarde.

Usted o el profesional que le receta tiene derecho a pedirnos un tipo de apelación especial que se denomina una "**excepción**". El profesional que le receta debe proporcionar una declaración que apoye su pedido de excepción. Ejemplos de una excepción:

- **Excepción al formulario**: usted necesita un medicamento que no está en nuestra lista de medicamentos cubiertos (formulario).
- **Excepción a una regla de cobertura:** usted considera que una regla de cobertura (como una autorización previa o un límite de cantidad) no debe aplicarse en su caso por motivos médicos.
- **Excepción de nivel:** usted debe tomar un medicamento no preferente que está en un nivel de costo compartido más alto y desea que nuestro plan lo cubra por un importe de costo compartido menor.

¿Quién puede solicitar una apelación?

Usted, el profesional que le receta o su representante puede solicitarla. Usted puede nombrar a un familiar, amigo, médico, abogado u otra persona para que actúe como su representante legal. Otras personas ya podrían estar autorizadas para representarle en virtud de la ley estatal. Para averiguar cómo designar a un representante, llámenos al: PLAN_APPEAL_PHONE Los usuarios de TTY deben llamar al: PLAN_APPEAL_TTY.

Información importante sobre sus derechos a apelar

Hay 2 tipos de apelaciones: estándar o acelerada (rápida)

Apelación estándar: recibirá una decisión por escrito en el plazo de 7 días (o 14 días si se trata de una apelación sobre el pago de un medicamento que ya recibió).

Apelación acelerada (rápida): recibirá una decisión por escrito en el plazo de 72 horas.

- Puede solicitar una apelación acelerada (rápida) si usted o el profesional que le receta cree que su salud podría perjudicarse seriamente si espera para una decisión estándar.
- No puede pedir una apelación acelerada si está solicitándonos el reembolso de un medicamento que ya recibió.
- Aceleraremos automáticamente su apelación si el profesional que le receta solicita una para usted (o apoya su solicitud) e indica que esperar una decisión estándar podría perjudicar seriamente su salud. Si solicita una apelación acelerada sin el apoyo del profesional que le receta, decidiremos si su salud requiere una apelación acelerada. Si no le otorgamos una apelación acelerada, procesaremos una apelación estándar.

Cómo solicitar una apelación

En el caso de una apelación **acelerada** (rápida), a manera más rápida de solicitar es por teléfono:

Teléfono: PLAN_APPEAL_PHONE1 TTY: PLAN_APPEAL_TTY1

Para una apelación **estándar**: Puede presentar una apelación por teléfono, por fax, en línea o enviando por correo una carta a la dirección que sigue.

Teléfono: PLAN_APPEAL_PHONE2

TTY: PLAN_APPEAL_TTY2

Fax: PLAN_APPEAL_FAX
En línea: PLAN_APPEAL_WEB

Dirección: PLAN_APPL_ORG
PLAN_APPL_ATTN
PLAN_APPL_ADDR1
PLAN_APPL_ADDR2
PLAN_APPL_CITY, PLAN_APPL_STATE PLAN_APPEAL_ZIP

Qué debe incluir con su solicitud de apelación

- Su nombre, dirección y número de afiliado
- Los motivos por los que está apelando
- Cualquier prueba que desee adjuntar para respaldar su caso
- Declaración de apoyo del profesional que le receta

Qué ocurre después

Después de su apelación, revisaremos su caso y le proporcionaremos una decisión. Si alguno de los medicamentos que solicitó se sigue denegando, puede pedir el siguiente nivel de apelación, que es una revisión independiente de su caso a cargo de un revisor externo a su plan. Si no está de acuerdo con esa decisión, tendrá derecho a seguir apelando. Se le notificarán sus derechos de apelación si eso sucede.

Obtenga ayuda y más información

- **PLAN_NAME1** Teléfono sin cargo: PLAN_APPEAL_PHONE3
  Los usuarios de TTY deben llamar al: PLAN_APPEAL_TTY3
  PLAN_APPEAL_HRS
  PLAN_APPEAL_WEB1
- **1-800-MEDICARE** (1-800-633-4227); los usuarios de TTY deben llamar al: 1-877-486-2048
- **Centro de derechos de Medicare:** 1-888-HMO-9050 (1-888-466-9050)
- **Localizador Elder Care:** 1-800-677-1116 o Eldercare.acl.gov/Public/Index.aspx para buscar ayuda en su comunidad.
- **Programa de Asistencia con el Seguro Médico del estado:** llame al Programa de

Asistencia con el Seguro Médico de su estado para asesoría gratuita y personalizada sobre seguros de salud. Visite shiphelp.org o llame al 1-877-839-2675 para obtener el número de su SHIP local.

Recibir información en otro formato

Usted tiene derecho a obtener información de Medicare en un formato accesible, como impreso en letras grandes, en Braille o en audio. También tiene derecho a presentar una queja si considera que se le ha discriminado. Visite Medicare.gov/about-us/accessibility-nondiscrimination-notice o llame al 1-800-MEDICARE (1-800-633-4227) para obtener más información. Los usuarios de TTY pueden llamar al 1-877-486-2048.

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una recopilación de información a menos que muestre un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es 0938-0976. Esta recopilación de información es para el aviso que los planes de medicamentos de Medicare deben proporcionar cuando un medicamento se deniega en su totalidad o en parte. Se calcula que el tiempo necesario para completar esa recopilación de información es, en promedio, inferior a 30 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar los recursos de datos existentes, reunir los datos necesarios y revisar y completar la recopilación de información. Esta recopilación de información es obligatoria en virtud de la sección 1860D-4(g)(h) de la Ley y la autoridad regulatoria establecida en la subparte M de la parte 423 en 42 CFR 423.568 y 423.572. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Solicitud de redeterminación de denegación de medicamentos recetados de Medicare

PLAN_NAME4 rechazó su solicitud de cobertura de (o pago de) FN_DRUG_SMRT_LABEL1. Tiene derecho a solicitarnos una redeterminación (apelación) de nuestra decisión. **Utilice este formulario para apelar esta decisión.**

- Puede solicitar una apelación dentro de los 65 días a partir de la fecha de nuestro Aviso de denegación de cobertura de medicamentos recetados de Medicare.
- También puede presentar una apelación a través de nuestro sitio web en PLAN_APPEAL_WEB3.
- Las solicitudes de apelación acelerada se pueden realizar por teléfono al PLAN_APPEAL_PHONE6.

Su médico puede solicitar una apelación en su nombre. Si desea que otra persona (como un familiar o un amigo) presente una apelación en su nombre, esa persona debe ser su representante. Llámanos al PLAN_APPEAL_PHONE7 para obtener información sobre cómo nombrar a un representante.

Información sobre los inscritos en el plan

Nombre del inscrito:_____

Número de identificación de miembro: _____ Fecha de nacimiento (MM/DD/AAAA): _____

Dirección de envío: _____

Ciudad, Estado, Código postal: _____

Teléfono: _____

Información sobre recetas y médicos que recetan

Nombre del medicamento que usted solicitó:_____

Concentración/cantidad/dosis: _____

Nombre del prescriptor: _____

Dirección del consultorio: _____

Ciudad, Estado, Código postal: _____

Teléfono del consultorio: _____ Fax del consultorio: _____

Persona de contacto del consultorio:_____

¿Ya compró este medicamento? Sí ☐ No ☐

En caso afirmativo:

Fecha de compra: _____ Monto pagado: _____ (adjuntar copia del recibo)

Nombre de la farmacia:_____

Número de teléfono de la farmacia: _____

¿Necesita una decisión acelerada (rápida)?

☐ **Marque esta casilla si cree que necesita una decisión dentro de 72 horas.** Si tiene una declaración de respaldo de su médico prescriptor, adjúntela a esta solicitud.

- Si usted o su médico creen que esperar 7 días para recibir una decisión estándar podría perjudicar gravemente su vida, su salud o su capacidad de recuperar la función máxima, puede solicitar una decisión acelerada (rápida).
- Si su médico le indica que esperar 7 días podría perjudicar gravemente su salud, le daremos automáticamente una decisión dentro de las 72 horas. No puede solicitar una apelación acelerada si nos pide que le reembolsemos el dinero por un medicamento que ya recibió.
- Si no obtiene el apoyo de su médico para una apelación acelerada, decidiremos si su caso requiere una decisión rápida.

Explique por qué cree que este medicamento debería estar cubierto

- Adjunte cualquier información adicional que crea que pueda ayudar a su caso, como una declaración de su médico o registros médicos.
- Incluya una copia del Aviso de denegación de cobertura de medicamentos recetados de Medicare
- Su médico deberá explicarle por qué no puede cumplir con las reglas de cobertura de nuestro plan y/o por qué los medicamentos requeridos por el plan no son médicamente apropiados para usted.
- Otra información que debemos considerar: _____

  _____

Información representativa

Complete esta sección SOLAMENTE si la persona que realiza esta solicitud no es el afiliado ni el médico que recetó al afiliado. Debe adjuntar documentación que demuestre su autoridad para representar al afiliado (como un Formulario CMS-1696 completo o un equivalente escrito) si no se presentó en el nivel de determinación de cobertura. Para obtener más información sobre cómo designar a un representante, llámenos al PLAN_APPEAL_PHONE8.

Nombre del representante: _____

Relación con el inscrito: _____

Dirección de la calle: _____

Ciudad, Estado, Código postal: _____

Teléfono: _____

Firme y envíe este formulario

Firma de la persona que solicita la apelación (el afiliado, el médico que receta o el representante):

Firma: ____ Fecha: ____________

Envíe por fax o correo su formulario completo y cualquier información de respaldo a:

Dirección: PLAN_APPL_ORG3
PLAN_APPL_ADDR13
PLAN_APPL_ADDR23
PLAN_APPL_CITY3, PLAN_APPL_STATE3
PLAN_APPEAL_ZIP3

Número de fax: PLAN_APPEAL_FAX3

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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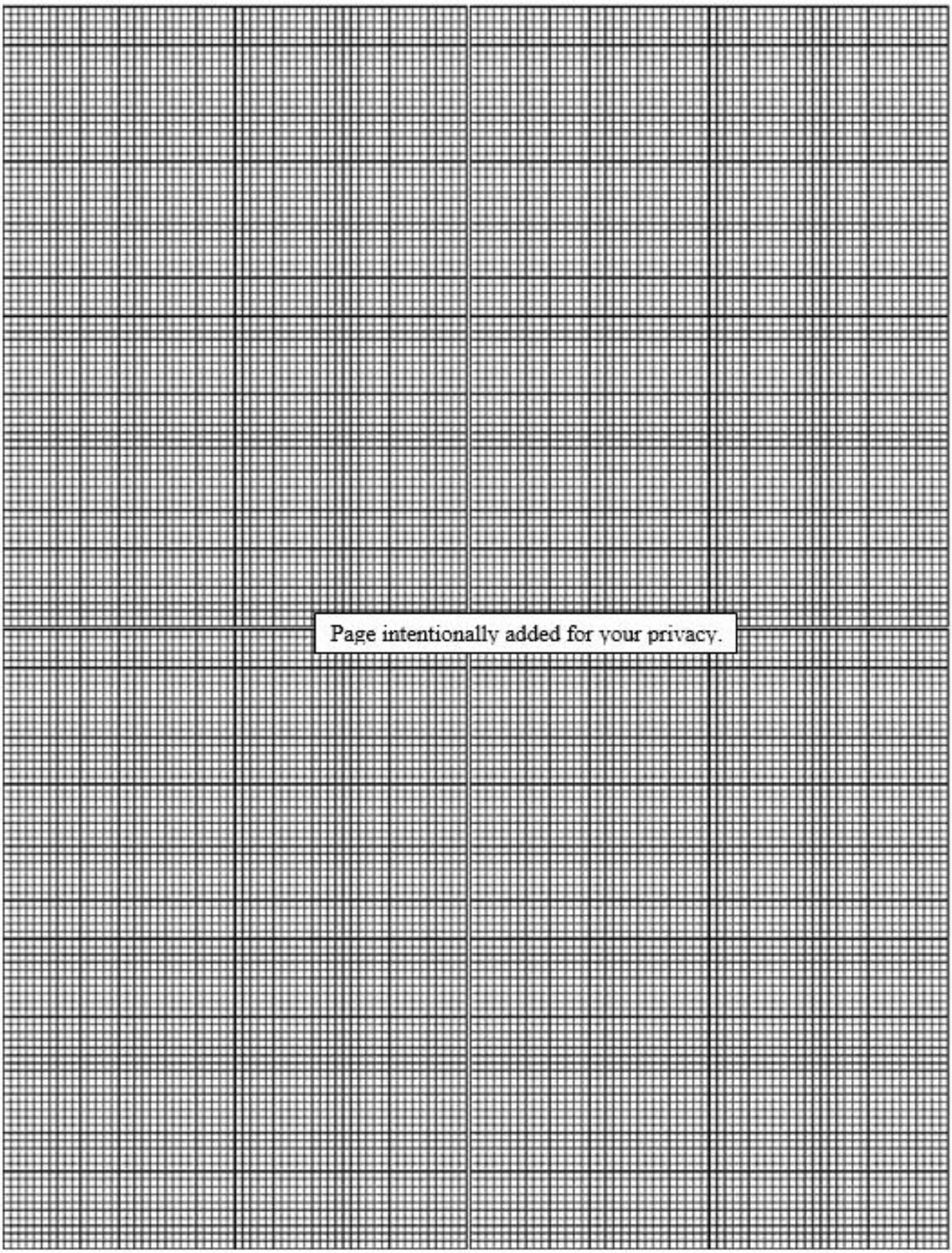
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS
FOR MEDICARE & MEDICAID SERVICES

10181 Scripps Gateway Ct., San Diego, CA 92131
1-800-788-2949

Notice of Denial of Medicare Part D Drug Coverage

Date: DECISION_DATE

Enrollee Name: MBR_FIRST_NAME1 MBR_LAST_NAME1

Member Number: MBR_MEMBER_NO

Coverage of your drug was denied

We denied coverage under Medicare Part D for the following drug(s) you or your prescribing provider asked for: FN_DRUG_SMRT_LABEL

Why was coverage for this drug denied?

We denied coverage for this drug because :

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

APPROVAL_LENGTH_STR

Share this notice with your prescribing provider and discuss next steps. If your prescribing provider asked for coverage for this drug on your behalf, we already shared this denial notice with them.

You have the right to appeal this decision

You have the right to ask us to review our decision by asking us for an appeal within 65 calendar days of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late.

You or your prescribing provider have the right to ask us for a special type of appeal called an **"exception."** Your prescribing provider must provide a statement to support your exception request. Examples of an exception are:

- **Formulary exception:** you need a drug that's not on our list of our covered drugs (formulary).
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- **Tiering Exception:** you need to take a non-preferred drug that's on a higher cost-sharing tier, and you want our plan to cover the drug at a lower cost-sharing amount.

Who can ask for an appeal?

You, your prescribing provider, or your representative can ask for an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative. To learn how to appoint a representative, call us at: PLAN_APPEAL_PHONE. TTY users call: PLAN_APPEAL_TTY.

Important Information About Your Appeal Rights

There are 2 kinds of appeals: standard or expedited (fast)

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Expedited appeal (fast): you'll get a written decision within 72 hours.

- You can ask for an expedited (fast) appeal when you or your prescribing provider believe that your health could be seriously harmed by waiting for a standard decision.
- You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already received.
- We'll automatically expedite your appeal if your prescribing provider asks for one for you (or supports your request) and indicates that waiting for a standard decision could seriously harm your health. If you ask for an expedited appeal without support from your prescribing provider, we'll decide if your health requires an expedited appeal. If we don't give you an expedited appeal, we'll process a standard appeal.

How to ask for an appeal

For an **expedited** (fast) appeal, phone is the fastest way to ask:

Phone: PLAN_APPEAL_PHONE1 TTY: PLAN_APPEAL_TTY1

For a **standard** appeal: You can file an appeal by phone, by fax, online, or by mailing a letter to the address below.

Phone: PLAN_APPEAL_PHONE2

TTY: PLAN_APPEAL_TTY2

Fax: PLAN_APPEAL_FAX

Plan Website: PLAN_APPEAL_WEB

Address: PLAN_APPL_ORG
PLAN_APPL_ATTN
PLAN_APPL_ADDR1
PLAN_APPL_ADDR2
PLAN_APPL_CITY, PLAN_APPL_STATE PLAN_APPEAL_ZIP

What to include with your appeal request

- Your name, address and member number
- The reasons you're appealing
- Any evidence you want to attach to support your case
- Supporting statement from your prescribing provider

What happens next

After you appeal, we'll review your case and give you a decision. If any of the drugs you asked for are still denied, you can ask for the next level of appeal, which is an independent review of your case by a reviewer outside of our plan. If you disagree with that decision, you'll have the right to further appeal. You'll be notified of your appeal rights if this happens.

Get help & more information

- **PLAN_NAME1** Toll Free: PLAN_APPEAL_PHONE3
  TTY users call:PLAN_APPEAL_TTY3
  PLAN_APPEAL_HRS
  PLAN_APPEAL_WEB1
- **1-800-MEDICARE** (1-800-633-4227), TTY users call: 1-877-486-2048
- **Medicare Rights Center:** 1-888-HMO-9050 (1-888-466-9050)
- **Elder Care Locator:** 1-800-677-1116 or Eldercare.acl.gov/Public/Index.aspx to find help in your community
- **State Health Insurance Program:** call your State Health Insurance Assistance Program for free, personalized health insurance counseling. Visit SHIPhelp.org or call 1-877-839-2675 to get the number for your local SHIP.

Get information in another format
You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0976. This information collection is for the notice Medicare drug plans must provide when a request for a drug is denied in whole or in part. The time required to complete this information collection is estimated to average less than 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1860D-4(g)(h) of the Act and the regulatory authority set in Subpart M of Part 423 at 42 CFR 423.568 and 423.572. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Request for Redetermination of Medicare Prescription Drug Denial

PLAN_NAME4 denied your request for coverage of (or payment for) FN_DRUG_SMRT_LABEL1. You have the right to ask us for a redetermination (appeal) of our decision. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at PLAN_APPEAL_WEB3.
- Expedited appeal requests can be made by phone at PLAN_APPEAL_PHONE6.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at PLAN_APPEAL_PHONE7 to learn how to name a representative.

Plan enrollee information

Enrollee name: _____

Member ID Number: _____ Date of birth (MM/DD/YYYY): _____

Mailing address: _____

City, State, ZIP code: _____

Phone: _____

Prescription & prescriber information

Name of drug you asked for: _____

Strength/quantity/dose: _____

Prescriber name: _____

Office address: _____

City, State, ZIP code: _____

Office phone: _____ Office fax: _____

Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: _____ Amount paid: _____ (attach copy of receipt)

Pharmacy name: _____

Pharmacy phone number: _____

Do you need an expedited (fast) decision?

☐ **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.

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: _____
  _____

Representative information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or a written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, Call us at PLAN_APPEAL_PHONE8.

Representative name: _____

Relationship to enrollee: _____

Street address: _____

City, State, ZIP code: _____

Phone: _____

Sign & submit this form

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

Signature: _____ **Date:** _____

Fax or mail your completed form and any supporting information to:

Address: PLAN_APPL_ORG3
PLAN_APPL_ADDR13
PLAN_APPL_ADDR23
PLAN_APPL_CITY3, PLAN_APPL_STATE3
PLAN_APPEAL_ZIP3

Fax Number: PLAN_APPEAL_FAX3

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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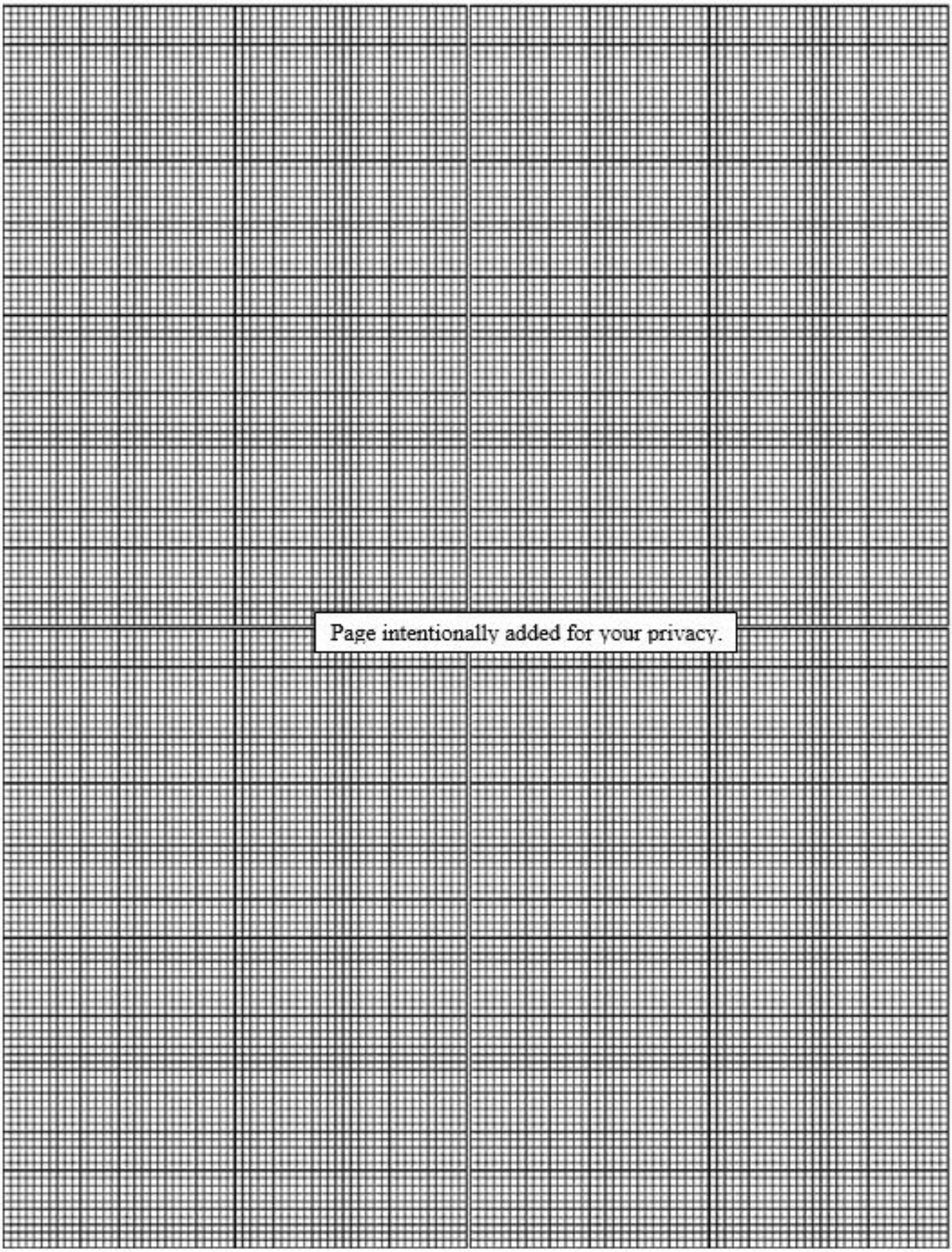
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DEPARTAMENTO DE SALUD Y SERVICIOS HUMANOS
CENTROS DE SERVICIOS DE MEDICARE Y MEDICAID

10181 Scripps Gateway Ct., San Diego, CA 92131
1-800-788-2949

Aviso de denegación de la cobertura de medicamentos de la Parte D de Medicare

Fecha: DECISION_DATE

Nombre del afiliado: MBR_FIRST_NAME1 MBR_LAST_NAME1

Número de afiliado: MBR_MEMBER_NO

Se denegó la cobertura de su medicamento

Hemos denegado la cobertura en virtud de la Parte D de Medicare para los siguientes medicamentos recetados que usted o el profesional que le receta solicitó:
FN_DRUG_SMRT_LABEL

¿Por qué se denegó la cobertura para este medicamento?

Denegamos la cobertura para este medicamento debido a:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

APPROVAL_LEN_STR_SP

Debe compartir este aviso con el profesional que le receta y analizar los pasos siguientes. Si el profesional que le receta solicitó cobertura para este medicamento en su nombre, ya compartimos esta negativa con él.

Usted tiene derecho a apelar esta decisión

Si desea hacerlo, tiene que solicitarnos una apelación en el plazo de 65 días calendario desde la fecha de este aviso. Si solicita una apelación después de transcurridos 65 días, deberá explicar por qué su apelación llega tarde.

Usted o el profesional que le receta tiene derecho a pedirnos un tipo de apelación especial que se denomina una "**excepción**". El profesional que le receta debe proporcionar una declaración que apoye su pedido de excepción. Ejemplos de una excepción:

- **Excepción al formulario**: usted necesita un medicamento que no está en nuestra lista de medicamentos cubiertos (formulario).
- **Excepción a una regla de cobertura:** usted considera que una regla de cobertura (como una autorización previa o un límite de cantidad) no debe aplicarse en su caso por motivos médicos.
- **Excepción de nivel:** usted debe tomar un medicamento no preferente que está en un nivel de costo compartido más alto y desea que nuestro plan lo cubra por un importe de costo compartido menor.

¿Quién puede solicitar una apelación?

Usted, el profesional que le receta o su representante puede solicitarla. Usted puede nombrar a un familiar, amigo, médico, abogado u otra persona para que actúe como su representante legal. Otras personas ya podrían estar autorizadas para representarle en virtud de la ley estatal. Para averiguar cómo designar a un representante, llámenos al: PLAN_APPEAL_PHONE Los usuarios de TTY deben llamar al: PLAN_APPEAL_TTY.

Información importante sobre sus derechos a apelar

Hay 2 tipos de apelaciones: estándar o acelerada (rápida)

Apelación estándar: recibirá una decisión por escrito en el plazo de 7 días (o 14 días si se trata de una apelación sobre el pago de un medicamento que ya recibió).

Apelación acelerada (rápida): recibirá una decisión por escrito en el plazo de 72 horas.

- Puede solicitar una apelación acelerada (rápida) si usted o el profesional que le receta cree que su salud podría perjudicarse seriamente si espera para una decisión estándar.
- No puede pedir una apelación acelerada si está solicitándonos el reembolso de un medicamento que ya recibió.
- Aceleraremos automáticamente su apelación si el profesional que le receta solicita una para usted (o apoya su solicitud) e indica que esperar una decisión estándar podría perjudicar seriamente su salud. Si solicita una apelación acelerada sin el apoyo del profesional que le receta, decidiremos si su salud requiere una apelación acelerada. Si no le otorgamos una apelación acelerada, procesaremos una apelación estándar.

Cómo solicitar una apelación

En el caso de una apelación **acelerada** (rápida), a manera más rápida de solicitar es por teléfono:

Teléfono: PLAN_APPEAL_PHONE1 TTY: PLAN_APPEAL_TTY1

Para una apelación **estándar**: Puede presentar una apelación por teléfono, por fax, en línea o enviando por correo una carta a la dirección que sigue.

Teléfono: PLAN_APPEAL_PHONE2

TTY: PLAN_APPEAL_TTY2

Fax: PLAN_APPEAL_FAX
En línea: PLAN_APPEAL_WEB

Dirección: PLAN_APPL_ORG
PLAN_APPL_ATTN
PLAN_APPL_ADDR1
PLAN_APPL_ADDR2
PLAN_APPL_CITY, PLAN_APPL_STATE PLAN_APPEAL_ZIP

Qué debe incluir con su solicitud de apelación

- Su nombre, dirección y número de afiliado
- Los motivos por los que está apelando
- Cualquier prueba que desee adjuntar para respaldar su caso
- Declaración de apoyo del profesional que le receta

Qué ocurre después

Después de su apelación, revisaremos su caso y le proporcionaremos una decisión. Si alguno de los medicamentos que solicitó se sigue denegando, puede pedir el siguiente nivel de apelación, que es una revisión independiente de su caso a cargo de un revisor externo a su plan. Si no está de acuerdo con esa decisión, tendrá derecho a seguir apelando. Se le notificarán sus derechos de apelación si eso sucede.

Obtenga ayuda y más información

- **PLAN_NAME1** Teléfono sin cargo: PLAN_APPEAL_PHONE3
  Los usuarios de TTY deben llamar al: PLAN_APPEAL_TTY3
  PLAN_APPEAL_HRS
  PLAN_APPEAL_WEB1
- **1-800-MEDICARE** (1-800-633-4227); los usuarios de TTY deben llamar al: 1-877-486-2048
- **Centro de derechos de Medicare:** 1-888-HMO-9050 (1-888-466-9050)
- **Localizador Elder Care:** 1-800-677-1116 o Eldercare.acl.gov/Public/Index.aspx para buscar ayuda en su comunidad.
- **Programa de Asistencia con el Seguro Médico del estado:** llame al Programa de

Asistencia con el Seguro Médico de su estado para asesoría gratuita y personalizada sobre seguros de salud. Visite shiphelp.org o llame al 1-877-839-2675 para obtener el número de su SHIP local.

Recibir información en otro formato

Usted tiene derecho a obtener información de Medicare en un formato accesible, como impreso en letras grandes, en Braille o en audio. También tiene derecho a presentar una queja si considera que se le ha discriminado. Visite Medicare.gov/about-us/accessibility-nondiscrimination-notice o llame al 1-800-MEDICARE (1-800-633-4227) para obtener más información. Los usuarios de TTY pueden llamar al 1-877-486-2048.

De acuerdo con la Ley de Reducción de Trámites de 1995, ninguna persona está obligada a responder a una recopilación de información a menos que muestre un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es 0938-0976. Esta recopilación de información es para el aviso que los planes de medicamentos de Medicare deben proporcionar cuando un medicamento se deniega en su totalidad o en parte. Se calcula que el tiempo necesario para completar esa recopilación de información es, en promedio, inferior a 30 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar los recursos de datos existentes, reunir los datos necesarios y revisar y completar la recopilación de información. Esta recopilación de información es obligatoria en virtud de la sección 1860D-4(g)(h) de la Ley y la autoridad regulatoria establecida en la subparte M de la parte 423 en 42 CFR 423.568 y 423.572. Si tiene preguntas sobre la precisión de los tiempos estimados o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Solicitud de redeterminación de denegación de medicamentos recetados de Medicare

PLAN_NAME4 rechazó su solicitud de cobertura de (o pago de) FN_DRUG_SMRT_LABEL1. Tiene derecho a solicitarnos una redeterminación (apelación) de nuestra decisión. **Utilice este formulario para apelar esta decisión.**

- Puede solicitar una apelación dentro de los 65 días a partir de la fecha de nuestro Aviso de denegación de cobertura de medicamentos recetados de Medicare.
- También puede presentar una apelación a través de nuestro sitio web en PLAN_APPEAL_WEB3.
- Las solicitudes de apelación acelerada se pueden realizar por teléfono al PLAN_APPEAL_PHONE6.

Su médico puede solicitar una apelación en su nombre. Si desea que otra persona (como un familiar o un amigo) presente una apelación en su nombre, esa persona debe ser su representante. Llámanos al PLAN_APPEAL_PHONE7 para obtener información sobre cómo nombrar a un representante.

Información sobre los inscritos en el plan

Nombre del inscrito:_____

Número de identificación de miembro: _____ Fecha de nacimiento (MM/DD/AAAA): _____

Dirección de envío: _____

Ciudad, Estado, Código postal: _____

Teléfono: _____

Información sobre recetas y médicos que recetan

Nombre del medicamento que usted solicitó: _____

Concentración/cantidad/dosis: _____

Nombre del prescriptor: _____

Dirección del consultorio: _____

Ciudad, Estado, Código postal: _____

Teléfono del consultorio: _____ Fax del consultorio: _____

Persona de contacto del consultorio: _____

¿Ya compró este medicamento? Sí ☐ No ☐

En caso afirmativo:

Fecha de compra: _____ Monto pagado: _____ (adjuntar copia del recibo)

Nombre de la farmacia: _____

Número de teléfono de la farmacia: _____

¿Necesita una decisión acelerada (rápida)?

☐ **Marque esta casilla si cree que necesita una decisión dentro de 72 horas.** Si tiene una declaración de respaldo de su médico prescriptor, adjúntela a esta solicitud.

- Si usted o su médico creen que esperar 7 días para recibir una decisión estándar podría perjudicar gravemente su vida, su salud o su capacidad de recuperar la función máxima, puede solicitar una decisión acelerada (rápida).
- Si su médico le indica que esperar 7 días podría perjudicar gravemente su salud, le daremos automáticamente una decisión dentro de las 72 horas. No puede solicitar una apelación acelerada si nos pide que le reembolsemos el dinero por un medicamento que ya recibió.
- Si no obtiene el apoyo de su médico para una apelación acelerada, decidiremos si su caso requiere una decisión rápida.

Explique por qué cree que este medicamento debería estar cubierto

- Adjunte cualquier información adicional que crea que pueda ayudar a su caso, como una declaración de su médico o registros médicos.
- Incluya una copia del Aviso de denegación de cobertura de medicamentos recetados de Medicare
- Su médico deberá explicarle por qué no puede cumplir con las reglas de cobertura de nuestro plan y/o por qué los medicamentos requeridos por el plan no son médicamente apropiados para usted.
- Otra información que debemos considerar: _____

  _____

Información representativa

Complete esta sección SOLAMENTE si la persona que realiza esta solicitud no es el afiliado ni el médico que recetó al afiliado. Debe adjuntar documentación que demuestre su autoridad para representar al afiliado (como un Formulario CMS-1696 completo o un equivalente escrito) si no se presentó en el nivel de determinación de cobertura. Para obtener más información sobre cómo designar a un representante, llámenos al PLAN_APPEAL_PHONE8.

Nombre del representante: _____

Relación con el inscrito: _____

Dirección de la calle: _____

Ciudad, Estado, Código postal: _____

Teléfono: _____

Firme y envíe este formulario

Firma de la persona que solicita la apelación (el afiliado, el médico que receta o el representante):

Firma: _____ **Fecha:** _____

Envíe por fax o correo su formulario completo y cualquier información de respaldo a:

Dirección: PLAN_APPL_ORG3
PLAN_APPL_ADDR13
PLAN_APPL_ADDR23
PLAN_APPL_CITY3,
PLAN_APPL_STATE3 PLAN_APPEAL_ZIP3

Número de fax: PLAN_APPEAL_FAX3

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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Page intentionally added for your privacy.

DECISION_DATE

MBR_FIRST_NAME3 MBR_LAST_NAME3
MBR_LINE1_ADDR1
MBR_LINE2_ADDR1
MBR_CITY1, MBR_STATE1 MBR_POSTAL_CODE1

RE: Prior Authorization Determination
Reference number: PA_NUMBER

Dear MBR_FIRST_NAME2 MBR_LAST_NAME2,

This is to inform you that your request for FN_DRUG_SMRT_LABEL on MRF_RECV_DATE has been received. After review of this request, it has been decided that an authorization is not needed for this drug. Listed below is/are the reason(s) an authorization for this drug is not needed:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT

The coverage of this drug may be subject to plan limitations as defined in your Evidence of Coverage booklet.

If you have any questions or comments about this information, please contact MedImpact at HELP_PHONE; 24 hours a day, 365 days a year (TTY users, please dial 711).

Sincerely,

Prior Authorization Department

cc: Dr. PHY_FIRST_NAME PHY_LAST_NAME
Fax: FN_PHY_FAX

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME1 MBR_MIDDLE_NAME MBR_LAST_NAME1
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY1, MBR_STATE1 MBR_POSTAL_CODE1

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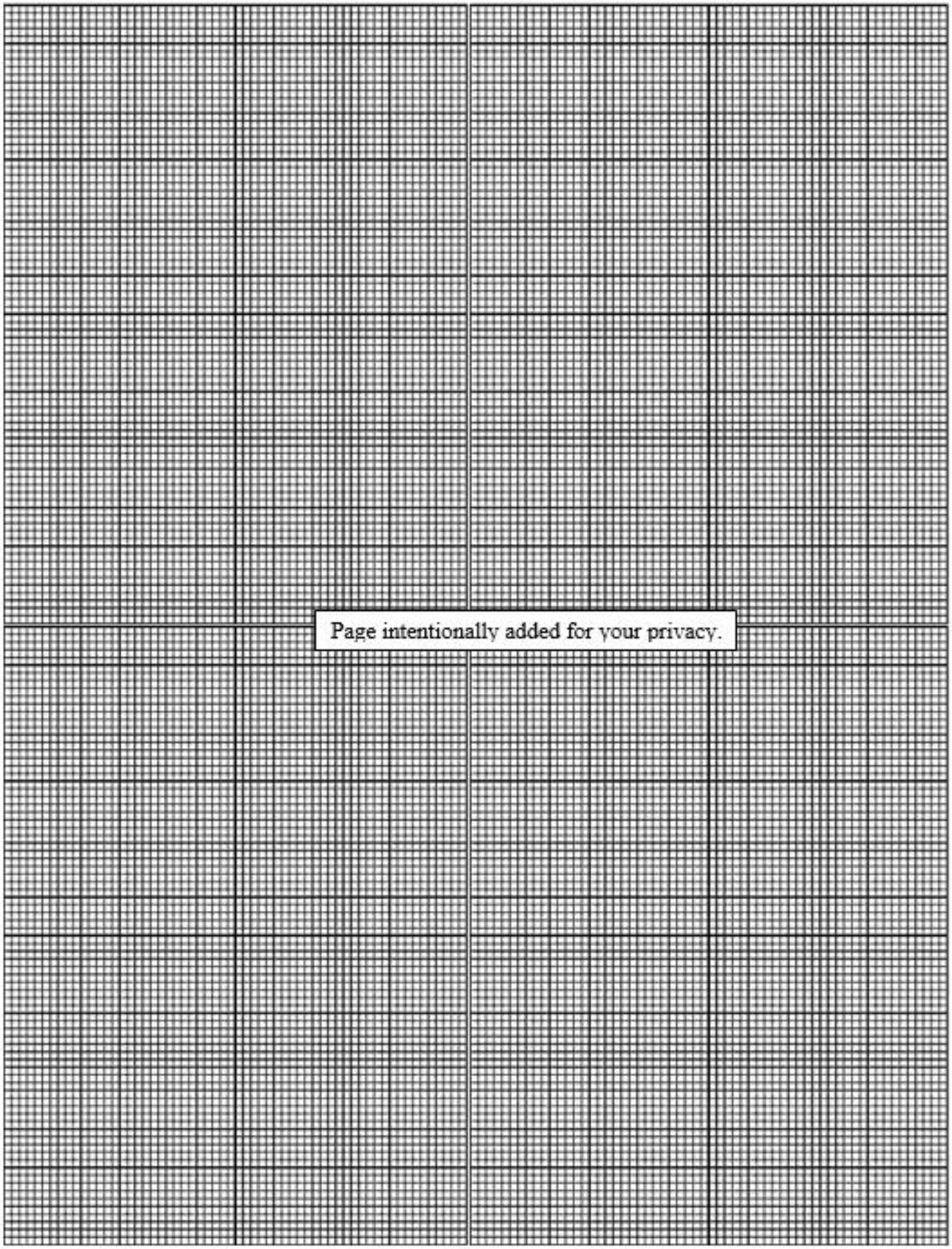
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DECISION_DATE

MBR_FIRST_NAME MBR_LAST_NAME
MBR_LINE1_ADDR1
MBR_LINE2_ADDR1
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

Member DOB: MBR_BIRTH_DATE
Prior Authorization Reference Number: PA_NUMBER
Plan Name: CARRIERHQNAME1
Plan Code: CARRIERHQCODE
Requested Drug/Service: FN_DRUG_SMRT_LABEL

RE: Request for Records/Additional Information for Coverage Authorization

Dear MBR_FIRST_NAME3 MBR_LAST_NAME3,

Certain prescription drugs or services require coverage authorization before they can be covered by PLAN_NAME1. When this occurs, your healthcare provider will need to contact us to request authorization for these drugs/services.

This letter is to notify you that we have received a request for authorization for coverage of the above prescription. In order to make a decision, we require the following records/additional information from your healthcare provider:

Reason1Text
Reason2Text
Reason3Text
FREE_TEXT
ADDL_FREE_TEXT1

Because your healthcare provider prescribed the above medication, we are sending a copy of this letter to let him/her know that we need the above information as soon as possible in order to make a decision. If we do not receive the requested information, we will be unable to process the request.

Please note that our request for additional information is for the purpose of determining coverage under **PLAN_NAME2**. The final decision to fill this and any prescription, regardless if the drug is covered by our plan or not, is between you and your healthcare provider.

If you have any questions, or need additional information, you or your healthcare provider may call MedImpact at 1-800-788-2949. Our call center is open 24 hours a day, 365 days a year. TTY users should call 711.

Your healthcare provider should fax the requested information to us at 1-858-790-6022.

Sincerely,

Prior Authorization Department

cc: PHY_FIRST_NAME PHY_LAST_NAME
FN_PHY_FAX

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Ct.
San Diego, CA 92131

PLAN_NAME
MBR_FIRST_NAME MBR_MIDDLE_NAME MBR_LAST_NAME
MBR_LINE1_ADDR
MBR_LINE2_ADDR
MBR_CITY, MBR_STATE MBR_POSTAL_CODE

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Notice of Case Status

DECISION_DATE

MBR_FIRST_NAME1 MBR_LAST_NAME1
MBR_LINE1_ADDR1
MBR_LINE2_ADDR1
MBR_CITY1, MBR_STATE1 MBR_POSTAL_CODE1

Member ID Number: MBR_MEMBER_NO
Case Number: PA_NUMBER

Dear MBR_FIRST_NAME2 MBR_LAST_NAME2:

Reason1Text DECISION_DATE1.
Reason2Text

Since we didn't give you an answer in the required time frame, we're required by law to forward your case file to an independent review organization within 24 hours. The independent review organization has a contract with Medicare and no connection to us.

What to do next

You have the right to ask us for a copy of your case file that we sent to the independent review organization. It will be provided to you free of charge.

You also have the right to submit additional evidence about your case. If you choose to submit additional evidence, mail or fax it as soon as possible to the independent review organization at:

Standard Mail
C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
P.O. Box 44166
Jacksonville, FL 32231-4166

Courier or Tracked Mail (e.g. FedEx or UPS):
Part D Drug Reconsiderations
301 W. Bay St., Suite 1110
Jacksonville, FL 32202

Fax: Standard Appeals: (833) 710-0580
Fax: Expedited Appeals: (833) 710-0579

Web Portal Address: https://www.c2cinc.com//Appellant-Signup

If you have questions, or to ask for a copy of your case file, contact PLAN_NAME2 Customer Services at HELP_PHONE, 24 hours a day, 7 days a week. TTY users should call 711.

Thank You,

PLAN_NAME1