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Request for Redetermination of Medicare Prescription Drug Denial

Because we, Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (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:

Address:
Healthfirst AbsoluteCare FIDA Plan
FIDA Participant Services
PO Box 5165
New York, NY 10274-5165

Fax Number:
1-855-633-7673

You may also ask us for an appeal through our website at www.healthfirst.org/mmp.
Expedited appeal requests can be made by phone at 1-877-779-2959.

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 (1-800-633-4227).

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Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐No

If "Yes":
Date purchased: _____Amount paid: $ _____(attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐**CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS If you have a supporting statement from your prescriber, attach it to this request.**

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____
_____
_____
_____

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

_____ **Date:** _____

Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan) is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

Participants generally must use network pharmacies to access their prescription drug benefit.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

You can get this information for free in other languages. Call 1-855-675-7630 and TTY/TDD: 711, 7 days a week from 8 am to 8 pm. The call is free.

Usted puede obtener esta información de forma gratuita en otros idiomas. Llame al 1-855-675-7630 y al TTY/TDD 711, los 7 días de la semana de 8:00 a.m. a 8:00 p.m. La llamada es gratuita.

Вы можете получить эту информацию бесплатно на других языках. Звоните по телефону 1-855-675-7630 или 711 (для пользующихся TTY/TDD) 7 дней в неделю с 8 утра до 8 вечера. Звонок бесплатный.

本資訊有其他語言版本供免費索取。請致電1-855-675-7630，聽力語言殘障服務專線TTY/TDD 711，服務時間每週七天，每天上午8時至晚上8時。以上均為免費電話。

이와 동일한 정보를 무상으로 다른 언어 버전으로도 얻으실 수 있습니다. 문의는 1-855-675-7630(TTY/TDD 711)으로 연중무휴 오전 8시에서 오후 8시 사이에 연락 주십시오. 통화는 무료입니다.

Ou kapab jwenn enfòmasyon sa yo gratis nan lòt lang yo. Rele nimewo 1-855-675-7630 ak TTY/TDD 711 pandan 7 jou pa semèn depi 8 am jiska to 8 pm. Koutfil la gratis.

È possibile ottenere queste informazioni gratuitamente in altre lingue chiamando il numero 1-855-675-7630 (utenti TTY/TDD: 711), 7 giorni alla settimana dalle 8 alle 20. La telefonata è gratuita.

You can ask for this notice in other formats, such as Braille or large print. Call 1-855-675-7630 or TTY: 711, 7 days a week from 8 am to 8 pm.

Healthfirst Medicare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan). The Participant Ombudsman may be reached toll-free at 1-844-614-8800, TTY 711 or online at icannys.org.