REQUEST FOR REDETERMINATION OF HEALTHFIRST ABSOLUTECARE FIDA PLAN (MEDICARE-MEDICAID PLAN) 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:
CVS Caremark – Appeals Department
MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

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 (TTY 711).

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.

Participant's Information

Participant's Name:		Date of Birth:
Participant's Address:		
City:	State:	Zip Code:
Phone:	Participant's ID Number:	

Complete the following section ONLY if the person making this request is not the Participant:

Requestor's Name:		
Requestor's Relationship to Participant:		
Address:		
City:	State:	Zip Code:
Phone:		

Representation documentation for appeal requests made by someone other than the Participant or the Participant's prescriber:

Attach documentation showing the authority to represent the Participant (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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048 or visit www.mymedicare.gov.

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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 Participant, or the Participant's prescriber or representative):	**Date:**

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

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 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.

The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide Participants/Members free, confidential assistance on any services offered by Healthfirst Health Plan, Inc. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY 1-888-867-4132).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY 1-888-542-3821）。