Request for Reconsideration of Medicare Prescription Drug Denial

You have the right to ask for an independent review of your Medicare drug plan's decision to deny coverage or payment for a prescription drug you requested. Use this form to ask for an independent review of your drug plan's decision. **You can also file a request online at c2cinc.com//Appellant-Signup.**

- You may ask for an independent review within 65 days of the date of the plan's Redetermination Notice.
- Your prescriber can file a reconsideration request on your behalf without being an appointed representative. If you want another person to file for you (like a family member or friend), you must appoint that person as your representative.

Plan enrollee information

Enrollee name: _____

Medicare number: _____ Date of birth (MM/DD/YYYY): _____

Mailing address: _____

City, state, ZIP code: _____

Phone: _____

Name of current Part D Drug Plan: _____

Plan number (e.g.H1234): _____

Prescription & prescriber information

Prescription drug you asked your plan to cover: _____

_____

Prescriber name: _____

Office address: _____

City, state, ZIP code: _____

Office phone: _____ Office fax: _____

Office contact person: _____

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 for a standard decision (provided within 7 days) 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 life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we didn't get the supporting statement from your prescriber supporting the request, OR the person acting for you files an appeal request but doesn't submit the right documentation of representation.

- If you don't get your prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

Explain why you think this drug should be covered

- Attach any information you have to support your review request, like a statement from your prescriber or any relevant medical records.
- **Include a copy of the plan Redetermination (Denial) Notice you got, if you have it.**
- Your prescriber will need to explain why you can't meet your plan's coverage rules and/or why the drugs required by the plan are not 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 or redetermination level.

Representative name: _____

Relationship to enrollee: _____

Mailing address: _____

City, state, ZIP code: _____

Phone: _____

Sign & submit this form

Signature of person asking for this review (the enrollee or the representative):

Signature: _____ **Date:** _____

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

Toll-free fax: Standard Appeals: (833) 710-0580

Expedited Appeals (833): 710-0579

Standard mail:

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

Courier or tracked mail (like FedEx or UPS):

C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 1110
Jacksonville, FL 32202

Alternately, submit your request online at https://www.c2cinc.com//Appellant-Signup.