



Request for Redetermination of Medicare Prescription Drug Denial

Because we 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. You can submit this form by mail, fax or online. To submit online, log in to our website with this [link](#). You'll find the coverage redetermination form at the bottom of the page. To submit the form by mail or fax, use this information:

Address:	Fax Number:
BlueCross BlueShield of Tennessee	423-591-9514
Medicare Part D Coverage Determinations and Appeals	
1 Cameron Hill Circle, Suite 51	
Chattanooga, TN 37402-0051	

Expedited appeal requests can be made by calling the Member Service number on the back of your ID card. From **Oct. 1 to March 31**, you can call us from 8 a.m. to 9 p.m. ET, 7 days a week. From **April 1 to Sept. 30**, we're available from 8 a.m. to 9 p.m. ET, Monday through Friday. If you call us outside these hours or on a holiday, our automated system will answer your call. You can leave a message for us, and we will call you back the next business day.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ ZIP Code _____

Phone _____

Enrollee's Plan ID Number _____

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

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ ZIP Code _____

Phone _____

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

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug _____ Strength/quantity/dose _____

Have you purchased the drug pending appeal? Yes No

If "Yes":

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

Name and telephone number of pharmacy: _____

Prescriber's Information:

Name _____

Address _____

City _____ State _____ ZIP Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions

If you or your prescriber believes 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):

Signature: _____ Date: _____