HIGHMARK WHOLECARE

Request for Medicare Prescription Drug Coverage Determination

Because Highmark Wholecare Medicare Assured[SM] 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:

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Address

Highmark Wholecare Medicare Assured[SM]
Four Gateway Center
444 Liberty Avenue, Suite 2100 Pittsburgh,
PA 15222-1222

Fax Number

1-888-447-4369

You may also ask us for an appeal through our website at www.highmarkwholecare.com

Expedited appeal requests can be made by phone to our Member Services Department.

Toll Free: 1-800-685-5209 TTY: 711

From October 1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can calll us Monday through Friday from 8 a.m. to 8 p.m.

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.

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Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____ State _____ Zip Code _____

City _____ Enrollee's Member ID # _____

Phone

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

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for 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). For more information on appointing a representative, contact your plan or 1-800-Medicare.

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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.

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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.

_____

_____

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_____

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

Signature: _____ Date: _____

Highmark Wholecare offers HMO plans with a Medicare contract. Enrollment in these plans depends on contract renewal.

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.

Call 1-800-685-5209 (TTY 711).

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-800-685-5209 (TTY 711).

小小贴士：如果您说普通话，欢迎使用免费语言协助服务。请拨 1-800-685-5209 (TTY 711).

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).