Request for Redetermination of Medicare Prescription Drug Denial

Because we Horizon Blue Cross Blue Shield of New Jersey 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:
Horizon Blue Cross Blue Shield of New Jersey
Attn: Medicare D Clinical Review
2900 Ames Crossing Road
Eagan, MN 55121

Fax Number:
1-800-693-6703

You may also ask us for an appeal through our website at **www.myprime.com**. Expedited appeal requests can be made by phone at **1-800-391-1906** (TTY/TDD **711**), 24 hours a day, seven days a week, Eastern Time.

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 Member 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), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.**

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 and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber

will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

_____

_____

_____

Signature of person requesting the appeal (the enrollee or the representative):

_____ Date: _____

MyPrime is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, a separate company providing pharmacy benefit management services.

This information is not a complete description of benefits. Contact the plan for more information. Limitations and restrictions may apply. Benefits may change on **January 1** of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-365-2223** (TTY **711**).
ATENCIÓN: Si habla otro idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-365-2223** (TTY **711**).

Horizon Insurance Company ("HIC") has a Medicare contract to offer HMO, HMO-POS, PPO and Part D Medicare plans, including group-Medicare Advantage plans and group Part D Prescription Drug plans. Enrollment in HIC Medicare products depends on contract renewal. Products are provided by HIC. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey.