Request for Redetermination of Medicare Prescription Drug Denial

Capital Health Plan (HMO) 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. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at www.capitalhealth.com/Medicare.
- Expedited appeal requests can be made by phone at 1-850-523-7441 or 1-877-247-6512 (TTY: 1-850-383-3534 or 1-877-870-8943) 8 am to 8 pm, seven days a week, Oct - Mar and 8 am - 8 pm, Monday - Friday, Apr - Sept. State of Florida members call 1-877-392-1532, 7 am – 7 pm.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at 1-850-523-7441 or 1-877-247-6512 to learn how to name a representative.

Plan enrollee information

Enrollee name: ______________________________

Member ID Number: ____________ Date of birth (MM/DD/YYYY): ____________

Mailing address: ______________________________

City, State, ZIP code: ______________________________

Phone: ______________________________

Prescription & prescriber information

Name of drug you asked for: ______________________________

Strength/quantity/dose: ______________________________

Prescriber name: ______________________________

Office address: ______________________________

City, State, ZIP code: ______________________________

Office phone: ____________ Office fax: ____________

Office contact person: ______________________________

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: ____________ Amount paid: ____________ (attach copy of receipt)

Pharmacy name: ______________________________

Pharmacy phone number: ______________________________

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 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't 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 level. For more information on appointing a representative, call us at 1-850-523-7441 or 1-877-247-6512.

Representative name: ____

Relationship to enrollee: ____

Street address: ____

City, State, ZIP code: ____

Phone: ____

Sign & submit this form

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

Signature: ____ **Date:** ____________

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

Address:
Capital Health Plan (HMO)
Attn: Medicare D Clinical Review
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

Fax Number:
855-212-8110

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at one of the numbers listed below. If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:
Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, FL 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8 am – 8 pm, seven days a week, Oct – Mar and 8 am – 8 pm, Monday – Friday, Apr – Sept. State of Florida members call 1-877-392-1532, 7 am – 7 pm.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Right select electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:
U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Have a disability? Speak a language other than English? Call to get help for free. 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap? Vous parlez une autre langue que l'anglais? Appelez pour obtenir une aide gratuite. 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية. 1-877-247-6512، جهاز الاتصال الهاتفي للصم/الهاتف النصي (TDD/TTY) 850-383-3534، أو 1-877-870-8943

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos Unterstützung zu erhalten. 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

ناتوانی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید.

1-877-247-6512 یا DDT/YTT به شماره 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશ કરતાં અન્ય ભાષા બો◌ો છો? લનશુ◌ુક મદદ મેળવવા કૉ◌ કરો. 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis? 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 1-877-247-6512, TTY/TDD 850-383-3534 lub 1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 1-877- 247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：1-877-247-6512; TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พการหรอเปลา? พดภาษาอนทไมใชภาษาองกฤษหรอเปลา? โทรเพอขอความชวยเหลอฟร 1-877-247-6512, TTY/TDD 850-383-3534 หรอ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí. 1-877-247-6512, TTY/TDD 850-383- 3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8:00 am – 5:00 pm at 850-383-3311 or 1-877-247-6512. Medicare members or prospective members call 850-523-7441 or 1-877-247- 6512 (TTY 850-383-3534 or 1-877-870-8943) 8 am – 8 pm, seven days a week, Oct – Mar and 8 am – 8 pm, Monday – Friday, Apr – Sept. State of Florida members call 1-877-392-1532, 7 am – 7 pm. Capital Health Plan contact information is located on our website:https://capitalhealth.com/contact

Approved by Compliance Committee: 8/23/2016; Revised 5/3/17; Revised 11/14/17; Revised 8/21/18; Revised 7/17/19; Revised 2/22/23; Revised 8/22/24; Revised 10/21/24