Redetermination Notice
Denial of Medicare Prescription Drug Coverage

Date: <Date>

Enrollee's name: <Name>
<Street Address>
<City, State Zip Code>

Enrollee's Medicare (HIC) number: <HICN>

Plan Name: <Neighborhood Health Plan of Rhode Island>

Contract ID: <Contract ID>

Formulary ID: <Formulary ID>

Plan ID: <Plan ID>

We agree with our initial coverage determination and are denying the following prescription drug(s) that you or your physician or other prescriber requested:

We denied this request because: _____

_____

_____

_____

What If I Don't Agree With This Decision?

You have the right to ask for an independent review (appeal) of our decision. If your case involves an exception request and your physician or other prescriber did not already provide your plan with a statement supporting your request, **your physician or other prescriber must provide a statement to support your exception request and you should attach a copy of this statement to your appeal request.** If you want to appeal our decision, you must request your appeal in writing within 60 calendar days after the date of this notice. You must mail or fax your written request to the independent reviewer at:

Requests from PDP and MA-PD Plans:
MAXIMUS Federal Services
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302

Customer Service:
Toll- free: (877) 456-5302

Fax Numbers:
Toll-free: (866) 825-9507
(585) 425-5301

Who May Request an Appeal?

You, your prescriber, or someone you name to act for you (your **representative**) may request an appeal. You can name a relative, friend, advocate, attorney, provider, or someone else to act for you. An Appointment of Representation is not needed if the person appealing is your prescriber or is authorized under State law to act for you (for example, through a health care power of attorney or health care proxy).

You can call us at: ( ) _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TTY ( ) _____.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

For more information about your appeal rights, call us or see your Evidence of Coverage.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal for cases that involve coverage, if you or your provider believes that your health could be seriously harmed by waiting up to 7 days for a decision. If your request to expedite is granted, the independent reviewer must give you a decision no later than 72 hours after receiving your appeal (the timeframe may be extended in limited circumstances).

- **If the provider who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the provider indicates that waiting for 7 days could seriously harm your health, **the independent reviewer will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a provider, the independent reviewer will decide if your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (7 days) - You can request a standard appeal for a case involving coverage or payment. The independent reviewer must give you a decision no later than 7 days after receiving your appeal (the timeframe may be extended in limited circumstances).

When the Independent Reviewer Can Extend the Timeframe for Making a Decision –

The timeframe may be extended if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request. The timeframe also may be extended when the person acting for you files an appeal request but does not submit proper documentation of representation. In both situations, the independent reviewer may toll (or stop the clock) for up to 14 days to get this information.

What Do I Include with My Appeal?

You should include your name, address, HIC number, the reasons for appealing, and any evidence you wish to attach. If the appeal is made by someone other than you or your doctor or other prescriber, the person must submit a document appointing him or her to act for you. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary) or if you are asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your prescribing doctor or other prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) would not be as effective to treat your condition as the requested drug, or would harm your health.

How Do I Request an Appeal?

You, your prescriber or your representative should mail or fax your written appeal request to:

<Insert Part D QIC address **and** fax number>

What Happens Next? If you appeal, the independent reviewer will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can appeal to an administrative law judge (ALJ) if the value of your appeal is at least $130. If you disagree with the ALJ decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact Information:

If you need information or help, call **us** at:
Toll Free: 1-844-812-6896
TTY: 711

Other Resources To Help You:

Medicare
1-800-MEDICARE (1-800-633-4227)
Medicare Rights Center
Toll Free: 1-888-HMO-9050
Elder Care Locator
Toll Free: 1-800-677-1116
RIPIN Healthcare Advocate
1-855-747-3224 (TTY 711)
The POINT
1-401-462-4444

Neighborhood Health Plan of Rhode Island is a health plan that contracts with both Medicare and Rhode Island Medicaid to provide the benefits of both programs to enrollees.
This information is available for free in other languages. Please call our Member Services at 1-844-812-6896 (TTY 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.
Esta información está disponible de forma gratuita en otros idiomas. Por favor llame a nuestro Departamento de Servicios para Miembros al 1-844-812-6896 (TTY 711) de 8 am a 8 pm, lunes-viernes; sábados de 8 am a 12 pm. Los sábados por la tarde, domingos y días festivos federales, se le pedirá que deje un mensaje. Su llamada será devuelta dentro del siguiente día laborable. La llamada es gratuita.
Estas informações estão disponíveis gratuitamente noutros idiomas. Por favor telefone para os Serviços dos Membros em 1-844-812-6896 (TTY 711), das 8 às 20 horas, de Segunda a Sexta-feira; e das 8 às 12 (meio-dia) aos Sábados. Nos Sábados à tarde, Domingos e feriados federais, poderá ser-lhe pedido que deixe uma mensagem. A sua chamada será respondida no próximo dia útil. Esta chamada é grátis.
ព័ត៌មាននេះមានផ្តល់ជូនឥតគិតថ្លៃជាភាសាផ្សេងទៀត។ សូមទូរស័ព្ទមកកាន់ផ្នែកសេវាកម្មសមាជិក តាមរយៈលេខ 1-844-812-6896 (TTY 711) ចាប់ពីម៉ោង 8 ព្រឹកដល់ 8 យប់ ពីថ្ងៃចន្ទ – សុក្រ និងចាប់ពីម៉ោង 8 ព្រឹកដល់ 12 ថ្ងៃត្រង់នៅថ្ងៃសៅរ៍។ រៀងរាល់រសៀលថ្ងៃសៅរ៍ ថ្ងៃអាទិត្យ និងថ្ងៃឈប់សម្រាករបស់សហព័ន្ធ លោកអ្នកនឹងត្រូវបានស្នើសុំឲ្យផ្ញើសារទុក។ គេនឹងហៅត្រលប់ទៅលោកអ្នកក្នុងរវាងថ្ងៃធ្វើការបន្ទាប់ ។ ការហៅទូរស័ព្ទគឺឥតគិតថ្លៃ។