

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”



NOTICE OF DENIAL OF MEDICARE PRESCRIPTION DRUG COVERAGE

Date:
<Date>

Enrollee's Name:
<Name>

Member Number:
<Member ID>

Your request was denied

We have denied coverage or payment under your Medicare Part D benefit for the following prescription drug(s) that you or your prescriber requested:
<requested drug>

Why did we deny your request?

We denied this request under Medicare Part D because <specific rationale for denial including any applicable Medicare coverage rule or Part D plan policy>.

Although your drug was denied under your Medicare Part D benefit, it may be covered under another benefit (i.e. Medicare Part B). Please call 1-800-Medicare for more information. Or call us at 1-844-812-6896. TTY users should call 711.

<Medicare Part D has denied your request, however, <Medicaid> has approved coverage/payment for the requested drug(s) <explain the conditions of approval in a readable and understandable format>. If you think Medicare Part D should have paid- you may appeal.

What If I Don't Agree With This Decision?

You have the right to appeal. If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline. You have the right to ask us for a **formulary exception** if you believe you need a drug that is not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a rule such as prior authorization or a quantity limit should not apply to you. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who May Request an Appeal?

You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, provider, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at: 1-844-812-6896 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**
- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 1-844-812-6896

Fax: (401) 709-7005

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

Appeals Coordinator
Neighborhood Health Plan of Rhode Island
910 Douglas Pike
Smithfield, RI 02917

What Happens Next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Get help & more information

- **Neighborhood Health Plan of Rhode Island: Toll Free:** 1-844-812-6896 **TTY users call:** 711
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- **Medicare Rights Center:** 1-888-HMO-9050
- **Elder Care Locator:** 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 លោកអ្នកនឹងត្រូវបានស្នើសុំឱ្យផ្ញើសារទុក។ គេនឹងហៅត្រលប់ទៅលោកអ្នកក្នុងរវាងថ្ងៃធ្វើការបន្ទាប់ ។ ការហៅទូរស័ព្ទគិតគិតថ្លៃ។