



## Request for Redetermination of Medicare Prescription Drug Denial

Upper Peninsula MI Coordinated Health 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 <https://www.express-scripts.com/consumer/site/coveragereviewredetermination>.
- Expedited appeal requests can be made by phone at 1-877-349-9324.

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 1-877-349-9324 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 believes 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 are 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 a 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 are not 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 1-877-349-9324.

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:**

Upper Peninsula Health Plan  
Attn: Pharmacy Department  
853 W. Washington St.  
Marquette, MI 49855

**Fax Number:**

1-906-225-4516

Upper Peninsula Health Plan (UPHP) MI Coordinated Health (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. Enrollment in UPHP MI Coordinated Health depends on contract renewal.