## Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for a prescription drug you requested, you have the right to ask for an independent review of the plan's decision. You may use this form to request an independent review of your drug plan's decision. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Please complete this form and mail, fax or transmit it to:

United States Postal Service (USPS): C2C Innovative Solutions, Inc. Part D Drug Reconsiderations P.O. Box 44166 Jacksonville, FL 32231 - 4166

**Enrollee Information:** 

UPS / FedEx ONLY:
C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 600

Jacksonville, FL 32202

Standard Appeals Fax: Toll Free (833) 710-0580

Expedited Appeals Fax: Toll Free (833) 710-0579

QIC Appeals Portal: https://www.c2cinc.com/Appellant-Signup

<u>Note About Representatives:</u> Your prescriber may file a reconsideration request on your behalf without being an appointed representative. If you want another individual, such as a family member or friend to request an independent review for you, that individual must be appointed as your representative.

Enrollee Name:		
Address:		
City:	State:	Zip Code:
Phone: ()		
Medicare Beneficiary Identifier #:  (From red, white and blue Medicare card)		
Date of Birth (MM/DD/YYYY):		
Name of current Part D Drug Plan:		
Complete the following section ONLY if the perprescriber (make sure to attach documentation purposes of this request):  Representative's Name:	n showing the person's a	authority to represent enrollee for
Representative's Relationship to Enrollee:		
Address:		
City:		
Phone: ()		
Prescription drug you asked your plan to		

## Representation documentation for appeal request made by someone other than enrollee or prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of the enrollee without being an appointed representative.

Prescribing Physician's or Other Prescrib	er's information:	
Prescriber Name:		
Office Address:		
City:	State:	Zip Code:
Office Phone: ()		
Office Fax: ()		
Office Contact Person:		
Expedited Decisions If you or your prescribing physician or other prescribing physician or other prescribing provided within 7 days) could seriously harm you for an expedited (fast) decision. If your prescribing could seriously harm your life or health or ability organization will automatically give you a decision 14 calendar days if your case involves an except from your doctor or other prescriber supporting the but does not submit proper documentation of represcriber's support for an expedited appeal, the condition requires a fast decision.	ur life, health, or abilitying physician or other play to regain maximum from within 72 hours. The person request, OR the person presentation. If you do	to regain maximum function, you can ask prescriber indicates that waiting 7 days function, the independent review his timeframe may be extended for up to ave not received the supporting statement son acting for you files an appeal request not obtain your physician's or other
Check this box if you believe you need a from your prescribing physician or other		
Please attach any additional information you have physician or other prescriber and relevant medic coverage criteria as stated in the Plan's denial lebe needed to explain why you cannot meet the Plan are not medically appropriate for you.	<u>cal records.</u> Please have etter or in other Plan de	ve your prescriber address the Plan's ocuments. Input from your prescriber will
Additional information we should consider:		
Important: Please include a copy of the Red from your drug plan if available.	letermination (denial)	Notice that you should have received
Signature of person requesting the appea	l (the enrollee or the	e representative):
		Date: