<Date>

<Name of Applicant>
<Mail Address>
<City, State Zip>

Dear <Name of Applicant>:

Request for Redetermination of Medicare Prescription Drug Denial

Because we Aspire Health Advantage (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. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:	Fax Number:
Aspire Health Plan	831-657-0703
Part D Appeals & Grievances Department	Toll free: 855-570-1600
10 Ragsdale Drive, Suite 101	
Monterey, CA 93940	

You may also ask us for an appeal through our website at www.aspirehealthplan.org. Expedited appeal requests can be made by phone toll free at 855-570-1600, TTY users should call 711.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name_____Date of Birth _____

Enrollee's Address _____

City_____State_____Zip Code _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

_____ Requestor's Relationship

to Enrollee _____ Address _____

_____ City

_____State_____Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug:_____Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐No

If "Yes":
Date purchased:_____Amount paid: $_____(attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State_____Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions
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 will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐**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.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____

_____

_____

_____

_____

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

_____**Date:** _____