Request for Redetermination of Medicare Prescription Drug Denial

Because we at AlohaCare Advantage Plus 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: AlohaCare
Attn: Grievance Coordinator
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Fax Number: 973-0811
Toll-free: 1-800-830-7222

You may also ask us for an appeal through our website at www.AlohaCare.org. Expedited appeal requests can be made by phone at 973-6395 or toll-free at 1-866-973-6395. TTY/TTD users call 1-877-447-5990.

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 Member 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

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Office Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

### 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.

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

________________________________________________________

**Date:** ____________