CareFirst BlueCross BlueShield
Medicare Advantage
10455 Mill Run Circle
Owings Mills, MD 21117-5559
carefirst.com/medicare

Plan Name: CareFirst BlueCross BlueShield Medicare Advantage Core (HMO) Contract ID: H6067
Formulary ID: 00021175 Plan ID: 001

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, or upheld its decision regarding an at-risk determination made under its drug management program, 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 or fax it to:

MAXIMUS, Federal Services
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302
Toll-free: (866) 825-9507
Fax for Enrollees: (720) 462-7575

Note about Representatives: 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 your representative. Contact your Medicare drug plan to learn how to name a representative.

Enrollee Information:

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 person making this request is not the enrollee or the enrollee's prescriber (make sure to attach documentation showing the person's authority to represent enrollee for purposes of this request):

Representative's Name _____

Representative's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____

Prescription drug you asked your plan to cover: _____

_____

Representation documentation for appeal requests 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 an enrollee without being an appointed representative.

Prescribing Physician's or Other Prescriber'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 prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

☐ **Check this box if you believe you need a decision within 72 hours (if you have a supporting statement from your prescribing physician, attach it to this request).**

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records. Please have your prescriber address the Plan's coverage criteria as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Additional information we should consider**:** _____

_____

_____

Important: Please include a copy of the Redetermination (denial) Notice that you should have received from your drug plan if available.

Signature of person requesting the appeal (the enrollee or the representative):

_____ **Date:** _____