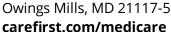
## CareFirst BlueCross BlueShield **Medicare Advantage**

10455 Mill Run Circle Owings Mills, MD 21117-5559





Plan Name: CareFirst BlueCross BlueShield Medicare Advantage Enhanced (HMO) Contract ID: H6067 Formulary ID: 00021300 Plan ID: 002

## 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	
Phone ()	
Medicare Beneficiary Identifier #(From red, white and blue Medicare card)	 <u> </u>
Date of Birth (MM/DD/YYYY)	
Name of current Part D Drug Plan	

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

H6067 MA8082 C MBR MA8082-1P (9/20)

		s request is not the enrollee or the enrerson's authority to represent enrollee	
Representative's Name			
Representative's Relationship to Enr	ollee		
Address			
City	State	Zip Code	
Phone ()			
Prescription drug you asked your	plan to cover:		
Attach documentation showing the or a written equivalent) if it was no	prescriber: e authority to represent ot submitted at the cover ay request an appeal on	nade by someone other than enroll the enrollee (a completed Form CM rage determination or redeterminati behalf of an enrollee without being	IS-1696 ion level.
Prescriber Name	_		
Office Address			
City			
Office Phone ()			
Office Fax ()	_		
Office Contact Person			
be provided within 7 days) could seriousk for an expedited (fast) decision. It days could seriously harm your life or organization will automatically give you call the country of the provided and the country of the country of the provided and the country of the provided and the country of the count	ously harm your life, healt lf your prescribing physician health or ability to regain ou a decision within 72 hoes an exception request are prescriber supporting the report for an expedited appearance.	that waiting for a standard decision (with, or ability to regain maximum function or other prescriber indicates that we maximum function, the independent ours. This timeframe may be extended and we have not received the supporting request, OR the person acting for you expresentation. If you do not obtain you cal, the independent review organization.	on, you can raiting 7 review I for up to sig files an ur
☐ Check this box if you believe you statement from your prescribin		in 72 hours (if you have a supportir this request).	ıg

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:

Please attach any additional information you have related to your appeal such as a statement from your