Request for Redetermination of Medicare Prescription Drug Denial

Use this form to file an appeal (request for us to reconsider our decision) if we denied your request for coverage of (or payment for) a prescription drug. You have 65 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to file an appeal.

Who can make a request? You, your prescriber, or a family member or friend may ask for an appeal on your behalf. If you want a family member or friend to request an appeal for you, that person must be your representative. Please call us to learn how to name a representative.

Member information

Full name _____

Address _____

City _____ State _____ ZIP code _____

UnitedHealthcare member ID number _____

Date of birth _____

Phone number _____

Complete the following section only if you're completing this form for the member.

Representative information

Full name _____

Address _____

City _____ State _____ ZIP code _____

Relationship to member _____

Note: If you are completing this form for the member and you aren't their prescriber, you will need to fill out a separate Appointment of Representative (CMS 1696) form if you haven't already done so.

Prescription drug information

Drug name _____

Drug strength/quantity/dose _____

Have you already purchased the drug pending approval? ☐ Yes ☐ No

If you answered "Yes", please provide the following information:

Date purchased _____

Amount paid $_____ (include a copy of the receipt)

Pharmacy name _____

Pharmacy phone number _____

Prescriber information

Name _____

Address _____

City _____ State _____ ZIP code _____

Office phone number _____

Office fax number _____

Office contact person _____

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

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Does your appeal need to be expedited? Expedited (fast) appeals are only for drugs that haven't been provided yet and only if you and your prescriber believe that waiting 7 days for a standard decision will place your life, health or ability to regain function in serious jeopardy. Expedited appeals are resolved within 72 hours of when we receive them. If you don't get 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.

☐ Please check this box if you need an expedited decision within 72 hours.

If you have a supporting statement from your prescriber, attach it to this request.

Signature

_____ _____

Member or authorized representative signature Date

Ready to send the completed form?

This form may be sent to us by mail or fax:

UnitedHealthcare
Appeals and Grievances Department
P.O. Box 6106, MS CA120-0368
Cypress, CA 90630

Standard appeal fax: 1-866-308-6294
Expedited appeal phone number: 1-800-595-9532

You may also ask us for an appeal by visiting UHCMedicareSolutions.com.

Questions? We're here to help.

If you have any questions, please call Customer Service at the number on your member ID card.

Thank you for taking the time to complete this form. If we have more questions, we will contact you.