Clover Health

Request for Redetermination of Medicare Prescription Drug Denial

Because we, Clover Health, 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.

Send form by mail or fax:	**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. **Appeal through our website:** www.cloverhealth.com **Call for expedited appeal requests:** (855) 479-3657
Address: **CVS Caremark Part D** MC109; P.O. Box 52000 Phoenix, AZ 85072-2000 **Fax #:** (855) 633-7673	

Enrollee's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Phone Number: (___) ___ - ____	Birth Date:	
Enrollee's Plan ID #:		

Complete the following section ONLY if the person making this request is not the enrollee:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	State:	Zipcode:
Phone Number: (___) ___ - ____		
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", please provide the following information:	
Date purchased:	Amount paid: $ (attach copy of receipt)
Pharmacy:	Pharmacy Telephone:

Prescriber's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Office Phone:	Fax:	
Office Contact Person:		

Important Note: Expedited Decisions

If you or your prescriber believe that waiting seven 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 seven 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 IN 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 Appeal: (the enrollee, or the enrollee's prescriber or representative):	Date: