

# Clover Health

## Request for Reconsideration of Medicare Prescription Drug Denial

CVS Caremark Part D  
Svc/Appeals  
MC109; P.O. Box 52000  
Phoenix, AZ 85072-2000  
Phone: (844) 232-2316  
Fax: (855) 633-7673

**Use this form to request an independent review of your drug plan's decision.** Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, you have the right to ask for an independent review of the plan's decision. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Send this form by mail or fax to:

Plan Name: Clover Health  
Classic (HMO)  
Formulary ID: 00020354  
Contract ID: H8010  
Plan ID: 002

### Requests from PDP and MA-PD Plans

MAXIMUS Federal Services  
PART D Q.I.C.  
3750 Monroe Ave., Suite #703  
Pittsford, NY 14534-1302

Fax Number: (585) 425-5301  
Toll free phone number: (877) 456-5302  
Toll free customer service fax:  
(866) 825-9507

**Note about Representatives:** Your prescriber may file a reconsideration request of 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 appointed as your representative.

Enrollee Information:	
Enrollee Name:	
Address:	
City, State, Zip code:	
Phone Number: (    )	Birth Date (MM/DD/YYYY):
Medicare Beneficiary Identifier #: (From red, white and blue Medicare card)	
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:	Phone Number: (    )
Representative's Relationship to the Enrollee:	
Address:	
City, State, Zip code:	
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.	

