Clover Health

Request for Reconsideration of Medicare Prescription Drug Denial

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

Plan Name: Clover Health Classic (HMO)
Formulary ID: 00020376
Contract ID: H8010
Plan ID: 005

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:

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.	

Prescribing Physician's or Other Prescriber's Information:	
Prescriber Name:	
Office Address:	
City, State, Zip code:	
Office Phone: ( )	Office Fax: ( )
Office Contact Person:	

Important Note: 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 IN 72 HOURS**
(If you have a supporting statement from your prescribing physician or other prescriber, 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 a received from your drug plan if available.

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