Request for Redetermination of Medicare Prescription Drug Denial

Because we Humana 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. This form may be sent to us by mail or fax:

Address: Humana Grievances and Appeals
P.O. Box 14165
Lexington, KY 40512-4165

Fax Number: 1-855-251-7594

You may also ask us for an appeal through our website at www.humana.com/determination.

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.

<table>
<thead>
<tr>
<th>Enrollee’s Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee’s Name ______________________ Date of Birth ______________</td>
</tr>
<tr>
<td>Enrollee’s Address _____________________________________________</td>
</tr>
<tr>
<td>City ________________ State ______ Zip Code ______________</td>
</tr>
<tr>
<td>Phone __________________________</td>
</tr>
<tr>
<td>Enrollee’s Plan ID Number ______________</td>
</tr>
</tbody>
</table>

Complete the following section ONLY if the person making this request is not the enrollee:

| Requestor’s Name ________________________________________________ |
| Requestor’s Relationship to Enrollee ______________________________ |
| Address ________________________________________________________ |
| City ________________ State ______ Zip Code ______________ |
| Phone __________________________ |

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 Humana at 1-800-281-6918.

**Prescription drug you are requesting:**

Name of drug: ___________________ Strength/quantity/dose: ___________________

Have you purchased the drug pending appeal?  ☐ Yes  ☐ No

Are you requesting reimbursement of the drug pending appeal?  ☐ Yes  ☐ No

If “Yes”:
Date purchased: ________________ Amount paid: $ ________ (attach copy of receipt)
Name and telephone number of pharmacy: ______________________________

**Prescriber's Information**

Name ________________________________________________________________

Address ______________________________________________________________

City ___________________________ State _________ Zip Code ________________

Office Phone ___________________________ Fax ___________________________

Office Contact Person ________________________________________________

**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.

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EXPEDITED DECISIONS

Important Note: For an expedited appeal you, your authorized representative, or prescriber should contact us by telephone at 1-800-867-6601 or fax at 1-800-949-2961. If you or your prescriber believe that waiting 7 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 provides a supporting statement indicating that waiting 7 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.

☐ ONLY CHECK THIS BOX IF YOU NEED A DECISION WITHIN 72 HOURS AND YOU HAVE A SUPPORTING STATEMENT FROM YOUR PRESCRIBER, ATTACH IT TO THIS REQUEST.

Signature of person requesting the appeal (the enrollee, or the enrollee’s prescriber or representative):

________________________________________  Date: ____________

[Signature]

[QR Code]