



Request for Medicare D-SNP Prescription Drug Coverage Determination

Because Highmark Health Options Duals 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 D-SNP Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

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Address

Fax Number

Highmark Health Options Duals
Attn: Utilization Management
P.O. Box 535191
Pittsburgh, PA 15253-5191

1-833-559-2855

Expedited appeal requests can be made by phone to Member Services.

1-855-401-8251 (TTY: 711 or 1-800-232-5460), 8 a.m. – 8 p.m. 7 days a week from Oct. 1 through March 31. From April 1 through Sept. 30, our business hours are 8 a.m. – 8 p.m., Monday through Friday.

Who may make a request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.



Member's Information

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ ZIP Code _____

Phone _____ Member's Member ID # _____

Complete the following section **ONLY** if the person making this request is not the member or prescriber:

Requester's Name _____

Requester's Relationship to Member _____

Address _____

City _____ State _____ ZIP Code _____

Phone _____

Representation documentation for requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). 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":

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 _____

Important Note: Expedited Decisions

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 indicates 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.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 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 D-SNP Prescription Drug Coverage.

Signature of person requesting the appeal (the member, or the member's prescriber or representative):

Signature: _____ Date: _____



Highmark Health Options Duals complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation. Highmark Health Options Duals does not exclude people or treat them differently because of their race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

Highmark Health Options Duals provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in a different way, including large print, audio, and Braille.

Highmark Health Options Duals provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact Highmark Health Options Duals Member Services at 1-855-401-8251 (TTY: 711 or 1-800-232-5460), Monday – Friday, 8 a.m. – 8 p.m.

If you believe that Highmark Health Options Duals has failed to provide these services or discriminated against you in another way because of your race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation, you can file a complaint with Highmark Health Options Duals or the Delaware Division of Human and Civil Rights by mail, phone, or web form.

Highmark Health Options Duals
Attn: Appeals and Grievances
P.O. Box 890416
Camp Hill, PA 17089-0416
1-855-401-8251

Division of Human and Civil Rights
861 Silver Lake Blvd., Suite 145
Dover, DE 19904
302-739-4567
hho.fyi/ea-intake

If you need help filing a complaint, Highmark Health Options Duals and the Division of Human and Civil Rights are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights online at OCRPortal.hhs.gov, and by mail, phone, or email:

U.S. Department of Health and Human Services
200 Independence Avenue SW
HHH Building Room 509F
Washington, DC 20201
1-800-368-1019 (TTY: 1-800-537-7697)
OCRMail@hhs.gov

A printable version of the complaint form is available at hho.fyi/complaint-form.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-401-8251 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-401-8251. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-401-8251。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-401-8251。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-401-8251. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-401-8251. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-401-8251 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-401-8251. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-401-8251번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-401-8251. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-401-8251. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-401-8251 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-401-8251. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-401-8251. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-401-8251. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-401-8251. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-401-8251にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。