meridiancomplete

Request for Redetermination of Medicare Prescription Drug Denial

We at MeridianComplete (Medicare – Medicaid Plan) 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:
1 Campus Martius, Suite 750
Attn. Appeals
Detroit, MI 48226

Fax Number: 844-328-1906

You may also ask us for an appeal through our website at **mhplan.com**.
Expedited appeal requests can be made by phone at **855-898-1480** (TTY users should call **711**).

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.

Enrollee's Information
Enrollee's Name _____ Date of Birth _____
Enrollee's Address _____
City _____ State _____ Zip Code _____
Phone _____
Enrollee's Member ID Number _____
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 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 Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, 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.

_____

_____

_____

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

_____ Date: _____

MeridianComplete is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-855-580-1689** (TTY: **711**).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-580-1689** (TTY: **711**).

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1 Campus Martius, Suite 700
Detroit, MI 48226

1-855-580-1689
TTY: 711
www.mhplan.com

MeridianComplete (Medicare-Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianComplete does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianComplete:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 MeridianComplete Member Services. If you believe that MeridianComplete has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with MeridianComplete's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MeridianComplete's Grievance Coordinator is available to help you.

Mail: MeridianComplete
Attn: Medicare Grievance Coordinator
P.O. Box 44260
Detroit, MI 48244

Telephone: 1-855-580-1689
(TTY users should call 711)
Hours: Monday – Sunday, 8 a.m. to 8 p.m.
Fax: 1-313-294-5552
Email: medicaregrievances@mhplan.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <1-855-580-1689> (TTY: <711>).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <1-855-580-1689> (TTY: <711>).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電<1-855-580-1689>（TTY：<711>）。

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. <1-855-580-1689> (TTY: <711>) 번으로 전화해 주십시오.

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <1-855-580-1689> (TTY: <711>).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم <1-855-580-1689> (رقم هاتف الصم والبكم: <711>).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <1-855-580-1689> (телетайп: <711>).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો <1-855-580-1689> (TTY: <711>).

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - <1-855-580-1689> (TTY: <711>). کال کریں

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số <1-855-580-1689> (TTY: <711>).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <1-855-580-1689> (TTY: <711>).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। <1-855-580-1689> (TTY: <711>) पर कॉल करें।

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <1-855-580-1689> (ATS : <711>).

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <1-855-580-1689> (TTY: <711>).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: <1-855-580-1689> (TTY: <711>).