

Request for Redetermination of Medicare Prescription Drug Denial

Because we, Gateway Health Plan *Medicare Assured*[®] 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:	Fax Number:
Gateway Health Plan [®]	412-255-4503
Attention: Medicare Complaints Administrator	
US Steel Building, Floor 41	
600 Grant Street	
Pittsburgh, PA 15219-2704	

You may also ask us for an appeal through our website at <http://www.GatewayHealthPlan.com/Medicare>

Expedited appeal requests can be made by phone to Gateway's Member Services Department 8:00 a.m. to 8:00 p.m. seven (7) days a week at 1-800-685-5209. 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.

Gateway Health Plan *Medicare Assured*[®] *HMO SNP* is a Coordinated Care plan with a Medicare Advantage contract and a contract with the Pennsylvania Medicaid program.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Plan 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: _____

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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.

Would you like to attend or participate in a hearing? **Yes** **No**

I would like to attend in person. **I would like to participate by phone.**

Your rights during the grievance process:

- You (or your appointed representative) have the right to submit evidence or allegations of fact or law, in person or in writing.
- You (or your appointed representative) have the right to review any information related to the grievance process.
- You (or your appointed representative) have the right to have a Gateway Health Plan *Medicare Assured*[®] staff member assist you in this process.

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PLEASE NOTE: *If anyone other than the member has completed and signed this form, an Appointment of Representative Form must also be completed.*

You may obtain a copy of the Appointment of Representative form from our website (www.GatewayHealthPlan.com/Medicare) or by calling the number below.

Gateway Health Plan *Medicare Assured*[®] Member Services Department is available 8:00 a.m. to 8:00 p.m. seven (7) days a week. Members should call 1-800-685-5209. TTY users should call 711.

Please review the information on this form to be sure that the information is correct. Make any corrections that you feel are needed. You may also wish to provide additional information for reconsideration.

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

Date: _____

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