Request for Redetermination of Drug Denial

Because we, WellSense Medicare Advantage, 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 65 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:

WellSense Medicare Advantage
Attn: Member Appeals
100 City Square, Suite 200
Charlestown, MA 02129

Fax Number:

617-897-0805

You may also ask us for an appeal through our website at **wellsense.org/medicare**.

Expedited appeal requests can also be made by phone at 855-833-8128 or 711 (TTY/TDD).

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 Information			
Enrollee's name (last name, first name, middle initial)		Date of birth (mm/dd/yyyy)	
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 (last name, first 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/quality/dose
Have you purchased the drug pending appeal? ☐ Yes ☐ No	
If yes, date purchased	Amount paid: (attach receipt) $
Name and telephone number of pharmacy	

Prescriber's information			
Prescriber's name (last name, first name		Date of birth (mm/dd/yyyy)	
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.

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

Date