Request for Redetermination of Medicare Prescription Drug Denial

WellSense HEALTH PLAN

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. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at **wellsense.org/yourmedicare**.
- Expedited appeal requests can be made by phone at **855-833-8128 (TTY: 711)**.

Your prescriber can ask for an appeal on your behalf. If you want another person (like a family member or friend) to file an appeal for you, that person must be your representative. Call us at **855-833-8128 (TTY: 711)** to learn how to name a representative.

Plan enrollee Information			
Enrollee's name (last name, first name, middle initial)			Date of birth (mm/dd/yyyy)
Enrollee's mailing address	City	State	Zip code
Phone	Enrollee's member ID number		

Prescription & prescriber information			
Name of drug you asked for			Strength/quality/dose
Prescriber's name (last name, first name)			
Office Address	City	State	Zip code
Office phone	Office fax		
Office contact person			

Did you already purchase this drug? ☐ Yes ☐ No

If yes, date purchased	Amount paid (attach copy of receipt) $
Pharmacy name	Pharmacy phone number

Do you need an expedited (fast) decision?

☐ **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.

- 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. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you have already received.
- If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision.

Explain why you think this drug should be covered.

- Attach any additional information you think may help your case, like a statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage.
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider:

Representative information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed Form CMS-1696 or written equivalent) if it wasn't submitted at the coverage determination level. For more information on appointing a representative, call us at **855-833-8128 (TTY: 711)**.

Representative information			
Representative name (last name, first name, middle initial)		Relationship to enrollee	
Representative's mailing address	City	State	Zip code
Phone			

Sign & submit this form

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

Fax or mail your completed form and any supporting information to:

Address:

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

Fax Number:

617-897-0805