Request for Redetermination of Medicare Prescription Drug Denial

Because we, Neighborhood INTEGRITY, 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: CVS Caremark Part D Appeals and Exceptions 
PO BOX 52000, MC109 
Phoenix, AZ 85072-2000

You may also ask us for an appeal through our website at www.nhpri.org/INTEGRITY. Expedited appeal requests can be made by phone at 1-844-812-6896, TTY: 711, 8 am to 8 pm, Monday– Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

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.

<table>
<thead>
<tr>
<th>Enrollee’s Information</th>
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<tbody>
<tr>
<td>Enrollee’s Name</td>
<td>Date of Birth</td>
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<tr>
<td>Enrollee’s Address</td>
<td></td>
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<tr>
<td>City</td>
<td>State</td>
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<td>Phone</td>
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<tr>
<td>Enrollee’s Member ID Number</td>
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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:

5246_603EUNVA1

H9576_PHMRedetrmReqFormV2 Accepted 6/15/19
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.

____________________________________________________
____________________________________________________
____________________________________________________

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

Date: ____________________________

Neighborhood Health Plan of Rhode Island is a health plan that contracts with both Medicare and Rhode Island 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 Member Services at 1-844-812-6896 (TTY 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

ATENCIÓN: Si usted habla Español, servicios de asistencia con el idioma, de forma gratuita, están disponibles para usted. Llame a Servicios a los Miembros al 1-844-812-6896 (TTY 711), de 8 am a 8 pm, de lunes a viernes, de 8 am a 12 pm los Sábados. En las tardes de los Sábados, domingos y feriados, se le pedirá que deje un mensaje. Su llamada será devuelta dentro del siguiente día hábil. La llamada es gratuita.

ATENÇÃO: Se você fala Português, o idioma, os serviços de assistência gratuita, estão disponíveis para você. Os serviços de chamada em 1-844-812-6896 (TTY 711), 8 am a 8 pm, de segunda a sexta-feira; 8 am a 12 pm no sábado. Nas tardes de sábado, domingos e feriados, você pode ser convidado a deixar uma mensagem. A sua chamada será devolvida no próximo dia útil. A ligação é gratuita.