## Request for Redetermination of Medicare Prescription Drug Denial

Because we, Aspirus Health 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:
Atttn: Appeals and Grievances
Aspirus Health Plan
P.O. Box 51
Minneapolis, MN 55440-9972

Fax Number: 715-631-7439 or 1-855-931-4857 (toll free)

You may also ask us for an appeal through our website at www.aspirushealthplan.com/medicare. Expedited appeal requests can be made by phone at 1-855-931-4858 (TTY users can call 1-855-931-4852), 8 a.m. - 4:30 p.m., Monday - Friday.

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.

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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:			
Prescriber's Information			
Name			
Address			
City         Zip Code			
Office Phone Fax			
Office Contact Person			
Important Note: Expedited Decisions  If you or your prescriber believes 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:			

## **Notice of Nondiscrimination**

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

We provide aids and services at no charge to people with disabilities to communicate effectively with us. such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at 715-631-7411 (voice) or toll free at 1-855-931-4850 (voice), 715-631-7413 (TTY), or 1-855-931-4852 (TTY).

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the number on the back of your membership card or 715-631-7411 or toll free at 1-855-931-4850 (voice); 715-631-7413 or toll free at 1-855-931-4852 (TTY).

If you believe that Aspirus Health Plan 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 an oral or written grievance.

## Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call 715-631-7411 or toll free at 1-855-931-4850 (voice); 715-631-7413 or toll free at 1-855-931-4852 (TTY). You can also use these numbers if you need assistance filing a grievance.

## Written grievance

Mailing Address Attn: Appeals and Grievances Aspirus Health Plan P.O. Box 51 Minneapolis, MN 55440

Email: cagMA@aspirushealthplan.com

Fax: 715-631-7439

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.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

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715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ለተሳናቸው: 715-631-7413/1-855-931-4852).

ဟ်သျဉ်ဟ်သး-နမ့်ာကတ်၊ ကညီ ကိုဂ်အယိ, နမၤန့်၊ ကိုဂ်အတာ်မၤစားလ၊ တလက်ဘူဉ်လက်စာ့၊ နီတမံးဘဉ်သံ့နှဉ်လီးကိုး 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ក្នុ៖ បើសិនជាអ្នកនិយា ភាសារ័ខ្លុរ, រសវាជំនួយរ័ជ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំររីអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY715-631-7413/ 1-855-931-4852)។

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتحد، 11/1-485-631-7411/1-855-931-4852.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).