Request for Redetermination of Medicare Prescription Drug Denial

Because we, Absolute Total Care (Medicare-Medicaid 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:
Centene Corporation
Attn: Appeals and Grievances/Medicare Operations
7700 Forsyth Blvd
Saint Louis, MO 63105

Fax Number:
1-844-273-2671

You may also ask us for an appeal through our website at http://mmp.absolutetotalcare.com. Expedited appeal requests can be made by phone at 1-855-735-4398. TTY users should call 711. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on 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.

Enrollee's Information

Enrollee's Name_____ Date of Birth _____

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 _____

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 (1-800-633-4227 (TTY: 1-877-486-2048), 24 hours per day, 7 days per week).

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 _____ 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.

_____
_____
_____

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

_____ **Date** _____

Absolute Total Care (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

Limitations, copays, and restrictions may apply. For more information, call Absolute Total Care Member Services or refer to the Absolute Total Care Member Handbook.

Benefits and/or copays may change on January 1 of each year.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

You can get this information for free in other languages. Please call our Member Services number at 1-855-735-4398 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Puede obtener esta información en otros idiomas gratis. Por favor llame a nuestro número de Servicios para Afiliados al 1-855-735-4398 (TTY: 711) de 8 a.m. a 8 p.m., de lunes a viernes. Luego del horario de atención, los fines de semana y los días feriados federales, es posible que se le pida que deje un mensaje. Le devolveremos la llamada el próximo día hábil. La llamada es gratuita.

Notice of Non-Discrimination. Absolute Total Care (Medicare-Medicaid Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Absolute Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Absolute Total Care:
→ Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
→ Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Absolute Total Care's Member Services at 1-855-735-4398 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you believe that Absolute Total Care 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 a grievance by calling the number above and telling them you need help filing a grievance; Absolute Total Care's Member Services is available to help you.

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, DC 20201, 1-800–368–1019, (TDD: 1-800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Services
ATTENTION: If your primary language is not English, language assistance services are available to you, free of charge. Call 1-855-735-4398 (TTY: 711).
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-4398 (TTY: 711).
ملحوظة: إذا كنت لا تجيد التحدث باللغة الإنجليزية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-735-4398 (رقم هاتف الصم والبكم: 711).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-735-4398 (TTY: 711).
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-735-4398 (TTY: 711).
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-735-4398 (TTY: 711).
ATENÇÃO: Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-855-735-4398 (TTY: 711).
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 電 1-855-735-4398（TTY：711)。
RUAHSAKNAK: Mirang ttong hmang nan um silen, Mirang ttong thawn pehpar aw in a lak in bawm nak a um. Himi ah in contact thei asi: 1-855-735-4398 (TTY: 711).
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-735-4398 (TTY: 711) पर कॉल करें।
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-735-4398 (TTY: 711) 번으로 전화해 주십시오.
THEIHTERNAK: Mirang holh a thiammi na si ahcun, holh lei kongkau bawmchanh khawhnak a lak in nangmah caah a um. Hika hin au hna 1-855-735-4398 (TTY-711).
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-735-4398 (ATS : 711).
ဟ်သူဉ်ဟ်သးဘဉ်တက္ၢ်–ဖဲနမ့ၢ်တကတိၤဒဲးကလံးအကျိာ်ဘဉ်နှဉ်,ကျိာ်အတၢ်ဆီဉ်ထွဲမၤစၢၤအတၢ်ဖံးတၢ်မၤတဖဉ်အိဉ်ဝဲဇဉ်လၢနဂီၢ်လၢတလိဉ် ဟ့ဉ်အပှၤဘဉ်နှဉ်လီၤ.ကိးဘဉ် 1-855-735-4398 (TTY: 711) တက္ၢ်.
ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ የቋንቋ እገዛ አገልግሎቶች ያለ ምንም ክፍያ ለእርስዎ ሊሰጡ ይችላሉ። ወደ 1-855-735-4398 (TTY: 711) ይደውሉ።
သတိပြုရန်။ သင် မြန်မာစကားပြောပါက အခမဲ့ ဘာသာပြန် ဝန်ဆောင်မှုကို ရရှိနိုင်သည်။ 1-855-735-4398 (TTY: 711) ကိုခေါ်ပါ။