Pharmacy Benefit Dimensions®

Request for Redetermination of Medicare Prescription Drug Denial

Because Pharmacy Benefit Dimensions (PBD) 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:	Fax Number:
511 Farber Lakes Dr. Buffalo, NY 14221	(716) 580-5264

You may also ask us for an appeal through our website at www.pbdrx.com/medicare.
Expedited appeal requests can be made by phone at (716) 504-4444 or 1-800-667-5936 or, for TTY users 711, October 1 – March 31: Monday through Sunday from 8 a.m. to 8 p.m. ET, April 1 – September 30: Monday through Friday 8 a.m. to 8 p.m. ET.

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 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 _____ 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:** _____

Language Assistance Services

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-667-5936 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-667-5936 (TTY: 711).
Chinese	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 1-800-667-5936（TTY：711）。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-667-5936 (телетайп: 711).
French Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-667-5936 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-667-5936 (TTY: 711) 번으로 전화해 주십시오.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-667-5936 (TTY: 711).
Farsi	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-667-5936 (TTY: 711) تماس بگیرید.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-667-5936 (TTY: 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-667-5936 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر، فإن المساعدة المغوية المتاحة تتوافر لك بالمجان. اتصل برقم 1-800-667-5936 (رقم الهاتف الصم والبكم: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-667-5936 (TTY : 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-667-5936 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-667-5936 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-667-5936（TTY: 711）まで、お電話にてご連絡ください。
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-667-5936 (TTY: 711).

Pharmacy Benefit Dimensions®

Discrimination is Against the Law

Pharmacy Benefit Dimensions is a subsidiary of Independent Health and complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pharmacy Benefit Dimensions does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pharmacy Benefit Dimensions:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Pharmacy Benefit Dimensions' Member Services Department.

If you believe that Pharmacy Benefit Dimensions 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 with: Pharmacy Benefit Dimensions' Member Services Department, P.O. Box 1642, Buffalo, NY 14231, 1-800-667-5936, TTY users call 711, fax (716) 250-7163, PBDMedicareservicing@pbdrx.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pharmacy Benefit Dimensions' Member Services Department 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, D.C. 20201
1-800-368-1019, 800-537-7697
(TDD)

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