

Request for Redetermination of Medicare Prescription Drug Denial

Because we Humana 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: Humana Grievances and Appeals
P.O. Box 14165
Lexington, KY 40512-4165

Fax Number:
1-855-251-7594

You may also ask us for an appeal through our website at www.humana.com/determination.

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 Humana at 1-800-281-6918.

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? Yes No

Are you requesting reimbursement of 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 _____

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.

EXPEDITED DECISIONS

Important Note: For an expedited appeal you, your authorized representative, or prescriber should contact us by telephone at 1-800-867-6601 or fax at 1-800-949-2961. 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 provides a supporting statement indicating 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.

ONLY CHECK THIS BOX IF YOU NEED A DECISION WITHIN 72 HOURS AND YOU HAVE A SUPPORTING STATEMENT FROM YOUR PRESCRIBER, ATTACH IT TO THIS REQUEST.

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

Date: _____

