



**Request for Redetermination of Medicare Prescription Drug Denial**

Because we, PrimeTime 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:** PrimeTime Health Plan Grievance & Appeals  
PO Box 6029  
Canton, Ohio 44706

**Fax Number:** 330-363-3066

You may also ask us for an appeal through our website at [www.pthp.com](http://www.pthp.com)  
Expedited appeal requests can be made by phone at 330-363-7407 or toll-free at 1-800-577-5084. TTY line: 330-363-7460 or 1-800-617-7446. Hours of operation are Monday through Friday from 8 a.m. to 8 p.m. (October 1 – March 31 we are available 7 days a week, 8 a.m. to 8 p.m.). Office hours are Monday through Friday, 8 a.m. to 4:30 p.m.

**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:** \_\_\_\_\_