aetna®

Request for Redetermination of Medicare Prescription Drug Denial

Because we Aetna 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:
Aetna Medicare Part D Appeals & Grievances
PO Box 14579
Lexington, KY 40512

Fax Number:
724-741-4954

You may also ask us for an appeal through our website at **www.aetnamedicare.com**. Expedited appeal requests can be made by phone at **1-877-235-3755, (TTY 711)**.

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.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

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.

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

Our dual-eligible Special Needs Plan is available to anyone who has both Medical Assistance from the state and Medicare. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.