Request for Redetermination of Medicare Prescription Drug Denial

HAP CareSource™ MI Health Link (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 an appeal. You can send this to us by mail or fax:

Address:	Fax Number:
Express Scripts Attn: Medicare Appeals P.O. Box 66588 St. Louis, MO 63166-6588	1-877-852-4070

You may also ask us for an appeal through our website at Express-Scripts.com. You can ask for an expedited appeal by phone at 1-800-935-6103, (TTY users can call 1-800-716-3231 or 711), 24 hours a day, 7 days a week.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. You can ask another person (such as a family member or friend) to ask for an appeal for you. That person must be your representative. Call 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 _____

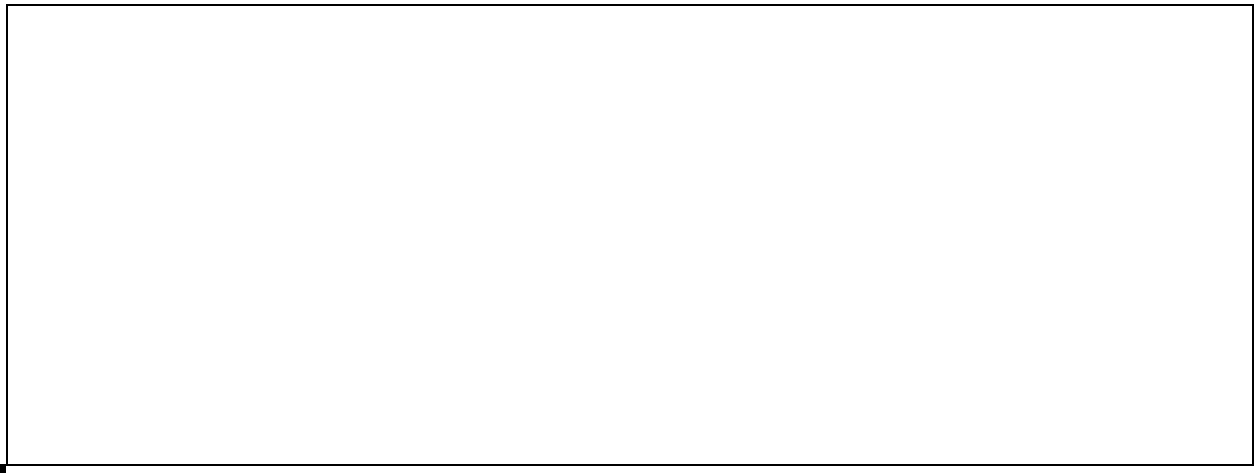
Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

<u>If you are not the enrollee:</u> 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 made at the coverage determination level. To learn more on naming a representative, call your plan or 1-800-Medicare.



Signature of person requesting the appeal (the enrollee or the representative):

Date:

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