Clover Health

Request for Reconsideration of Medicare Prescription Drug Denial

CVS Caremark Part D Svcs/Appeals
MC109; P.O. Box 52000
Phoenix, AZ 85072-2000
Phone: (855) 479-3657
Fax: (855) 633-7673

Plan Name: Clover Health
Formulary ID: 00017321
Contract ID: H5141
Plan ID: 001

Use this form to request an independent review of your drug plan's decision. Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, you have the right to ask for an independent review of the plan's decision. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Send this form by mail or fax to:

Requests from PDP and MA-PD Plans

MAXIMUS Federal Services
PART D Q.I.C.
3750 Monroe Ave., Suite #703
Pittsford, NY 14534-1302

Fax Number: (585) 425-5301
Toll free fax: (866) 825-9507
Toll free customer service fax: (877) 456-5302

Note about Representatives: Your prescriber may file a reconsideration request of your behalf without being an appointed representative. If you want another individual, such as a family member or friend, to request an independent review for you, that individual must be your representative. Contact your Medicare drug plan to learn how to name a representative.

Enrollee's Information:		
Name:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _	**Birth Date:**	
Enrollee's Medicare (HIC) number: (as shown on your Medicare card)		

Complete the following section ONLY if the person making this request is not the enrollee:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _		
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 Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of an enrollee without being an appointed representative.		

Prescription drug you asked your plan to cover:

Prescribing Physician's information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Office Phone:	Fax:	
Office Contact Person:		

Important Note: Expedited Decisions

If you or your prescribing physician or other prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION IN 72 HOURS**
(If you have a supporting statement from your prescriber, attach it to this request.

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records. Please include a copy of the Redetermination (denial) Notice you received from your drug plan with this request.

Additional information we should consider:

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