Request for Redetermination of Medicare Prescription Drug Denial

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. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at www.humana.com/denial.
- Expedited appeal requests can be made by phone at 1-800-451-4651.

Your prescriber may ask us for an appeal on your behalf. If you want another individual (like a family member or friend) to file an appeal for you, that person must be your representative. Contact us to learn how to name a representative.

Plan Enrollee Information

Enrollee's Name: _____

Member ID Number: _____Date of Birth(MM/DD/YYYY): _____

Mailing address: _____

City, State, ZIP code: _____

Phone: _____

Prescription & Prescriber information

Name of drug you asked for: _____

Strength/quantity/dose: _____

Prescriber name: _____

Office address: _____

City, State, ZIP Code: _____

Office phone: _____Office fax: _____

Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

Date purchased: _____ Amount paid:_____
(attach copy of receipt)

Pharmacy name: _____

Pharmacy phone number:

Do you need an expedited (fast) decision?

☐ **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).**

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: _____

_____

Representative Information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed 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.

Representative name: _____
Relationship to enrollee: _____
Street address: _____
City, State, ZIP code: _____
Phone: _____

Sign & submit this form

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

_____ Date: _____

Fax or mail your completed form and any supporting information to:

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

Fax Number:
1-877-556-7005