THE UNIVERSITY OF ARIZONA
HEALTH PLANS
University Care Advantage (HMO SNP)

2701 E. Elvira Road · Tucson, Arizona 85756
(877) 874-3930 · TTY 711 · Fax (866) 465-8340
www.UAHealthPlans.com

Request for Redetermination of Medicare Prescription Drug Denial

Because we, University Care Advantage, 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:

Attention: Manager, Grievance and Appeals
2701 E. Elvira Rd.
Tucson, Arizona 85756
Fax: 1-866-465-8340
grievance@uahealth.com

You may also ask us for an appeal through our website at www.UAHealthPlans.com.
Expedited appeal requests can be made by phone at 1-877-874-3930, TTY users please call 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.

This information is available for free in other languages. Please call our Customer Care Center at (877) 874-3930/ TTY: 711, 8am - 8pm, 7 days a week. Esta información está disponible gratis en otros idiomas. Favor de llamar al Centro de Atención al Cliente al (877) 874-3930/ TTY: 711 8am - 8pm, 7 días a la semana.

University Care Advantage is an HMO SNP plan with a Medicare Contract and a contract with the Arizona Medicaid program. Enrollment in University Care Advantage depends on contract renewal.

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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 _____

Representation documentation for appeal requests made by someone other than the 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 us at 1-877-874-3930 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:** _____