

Request for Redetermination of Medicare Prescription Drug Denial

Because Horizon NJ TotalCare (HMO D-SNP) 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:
Horizon NJ TotalCare (HMO D-SNP)
Attn: Medicare D Clinical Review
2900 Ames Crossing Road
Eagan, MN 55121

Fax Number:
1-800-693-6703

You may also ask us for an appeal through our website at **myprime.com**. Expedited appeal requests can be made by phone at **1-855-457-1346 (TTY 711)**, 24 hours a day, seven days a week.

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 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 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 call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

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 and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

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

Date: _____

[Use associated disclaimer when MyPrime is mentioned: <MyPrime is a pharmacy benefit website owned and operated by Prime Therapeutics LLC, a separate company providing pharmacy benefit management services.>]

This information is not a complete description of benefits. Contact the plan for more information. Limitations and restrictions may apply. Benefits may change on **January 1** of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-855-457-1346** (TTY **711**). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-457-1346** (TTY **711**)

Horizon NJ TotalCare (HMO D-SNP) is an HMO Medicare Advantage Dual Eligible Special Needs plan with a Medicare contract and a contract with the State of New Jersey Medicaid Program. Enrollment in Horizon NJ TotalCare (HMO D-SNP) depends on contract renewal. Products are provided by Horizon NJ Health. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross[®] and Blue Shield[®] names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon[®] name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey. © 2020 Horizon Blue Cross Blue Shield of New Jersey. Three Penn Plaza East, Newark, New Jersey 07105.

Y0090_H8298_EC004012_C

202-19-169

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Call Member Services at **1-844-498-9393 (TTY 711)** or the phone number on the back of your member ID card, if you need the free aids and services noted above and for **all other Member Services issues**.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon BCBSNJ's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to:

**Horizon BCBSNJ
Civil Rights Coordinator
PO Box 820
Newark, NJ 07101**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**. OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-844-498-9393 (TTY 711)**.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-844-498-9393 (TTY 711)**。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-844-498-9393 (TTY 711) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-844-498-9393 (TTY 711)**.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરી **1-844-498-9393 (TTY 711)**.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-844-498-9393 (TTY 711)**.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-844-498-9393 (TTY 711)**.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-844-498-9393** (رقم هاتف الصم والبكم 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-844-498-9393 (TTY 711)**.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-844-498-9393 (телетайп 711)**.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-844-498-9393 (TTY 711)**.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-844-498-9393 (TTY 711) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-844-498-9393 (TTY 711)**.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-844-498-9393 (ATS 711)**.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں

1-844-498-9393 (TTY 711).