



Clinical Review, 10181 Scripps Gateway Court, San Diego, CA 92131

Request for Redetermination of Medicare Prescription Drug Denial

Because PrimeWest Health 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: Clinical Review Department
PrimeWest Health
10181 Scripps Gateway Court
San Diego, CA 92131

Fax Number: **1-858-790-6060**

You may also ask us for an Appeal through our website at www.primewest.org/phc. Expedited Appeal requests can be made by phone at **1-877-600-4913**. TTY users call **1-800-627-3529** or **711**. The call is free. Hours are: October 1 – March 31, 7 days a week, 8 a.m. – 8 p.m.; April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m.

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.

Member's Information			
Member's Name _____	Date of Birth _____		
Member's Address _____			
City _____	State _____	Zip Code _____	
Phone _____			
Member's Plan ID Number _____			
Complete the following section ONLY if the person making this request is not the member:			
Requestor's Name _____			
Requestor's Relationship to Member _____			
Address _____			
City _____	State _____	Zip Code _____	
Phone _____			

Representation documentation for Appeal requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (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 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* 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.

<p>Signature of person requesting the Appeal (the member or the member’s prescriber or representative):</p> <p>_____ Date: _____</p>
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Prime Health Complete (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in Prime Health Complete (HMO SNP) depends on contract renewal.

1-866-431-0801 (toll free); TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ድኩሙንት የሚተረጎምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤတွဲရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ပတ်သည့်ပတ်သားဘဉ်တကွၢ်. ဖဲနမ့ၢ်လိၣ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်,ကိးဘဉ် လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တကွၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງ ໂທໂປໂຫຼ້າໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. PrimeWest Health does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
 PrimeWest Health
 3905 Dakota St
 Alexandria, MN 56308
 Toll Free: 1-866-431-0801
 TTY: 1-800-627-3529 or 711
 Fax: 1-320-762-8750
 Email: compliance@primewest.org

Auxiliary Aids and Services: PrimeWest Health provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Language Assistance Services: PrimeWest Health provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact PrimeWest Health at memberservices@primewest.org, or call Member Services at 1-866-431-0801 or TTY 1-800-627-3529 or 711. The call is free.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by PrimeWest Health. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
 U.S. Department of Health and Human Services
 Midwest Region
 233 N. Michigan Avenue, Suite 240
 Chicago, IL 60601
 Customer Response Center: Toll-free: 800-368-1019
 TDD Toll-free: 800-537-7697
 Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
 540 Fairview Avenue North, Suite 201
 St. Paul, MN 55104
 651-539-1100 (voice)
 800-657-3704 (toll-free)
 711 or 800-627-3529 (MN Relay)
 651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

PrimeWest Health Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-366-2906**. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-366-2906**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 **1-800-366-2906**。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 **1-800-366-2906**。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-366-2906**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-366-2906**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi **1-800-366-2906** sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-366-2906**. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-366-2906** 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-366-2906**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-366-2906**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-366-2906** पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-366-2906**. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-366-2906**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-366-2906**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-366-2906**. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、**1-800-366-2906**にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。