THE UNIVERSITY OF ARIZONA
HEALTH PLANS

University Care Advantage

(HMO SNP)

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:

Address:	Fax Number:
2701 E. Elvira	(866) 465-8340
Tucson, AZ 85756	

You may also ask us for an appeal through our website at www.universitycareadvantage.com
Expedited appeal requests can be made by phone at (877) 874-3930, 24 hours a day, 7 days a week.
TTY/TDD users should call (800) 367-8939.

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 _____

Prescription drug you are requesting:

Name of Drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? **Yes** No

If "Yes": _____

Prescriber's Information

Name_____

Address_____

City _____ State_____ Zip Code _____

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:**_____