Request for Redetermination of Medicare Prescription Drug Denial

Because we 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:
GuildNet Gold Plus FIDA Plan
Attn: Grievance and Appeals
PO Box 2807
New York, NY 10116-2807

Fax Number:
1-212-510-5320

You may also ask us for an appeal through our website at www.guildnetny.org.
Expedited appeal requests can be made by phone at 1-866-557-7300.

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.

Participant's Information

Participant's Name _____ Date of Birth _____

Participant's Address _____

City _____ State _____ Zip Code _____

Phone _____

Participant's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the participant:

Requestor's Name _____

Requestor's Relationship to Participant _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than participant or the participant's prescriber:

Attach documentation showing the authority to represent the participant (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.

H0811_GN143_Part D Redetermination_GN Approved

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 participant, or the participant's prescriber or representative):

_____ **Date:** _____

GuildNet Gold Plus FIDA Plan is a managed care plan that contracts with both Medicare and New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Program. Enrollment in GuildNet Gold Plus FIDA Plan depends on contract renewal.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

You can get this information for free in other languages. Call 1-800-815-0000 (TTY 1-800-662-1220), Monday through Sunday 8am to 8pm. The call is free.

Usted puede obtener esta información en otros idiomas gratis. Llame al 1-800-815-0000 o TTY/TDD al 1-800-662-1220, de lunes a domingo de 8am a 8pm. La llamada es gratis.

Queste informazioni sono disponibili gratuitamente in altre lingue. Chiamare il numero verde 1-800-815-0000 o 1-800-662-1220 mediante un telefono testuale per non udenti (TTY/TDD), da lunedì a domenica, dalle 8 alle 20. La chiamata è gratuita.

您可以免費獲得本信息的其他語言版本。請撥打1-800-815-0000 或*聽障／語障人士專線*(TTY/TDD) 1-800-662-1220，星期一至星期日上午8 時至晚上8 時。撥打該電話免費。

Вы можете бесплатно получить эту информацию на других языках. Позвоните по телефону **1-800-815-0000** и TTY/TDD **1-800-662-1220.** Служба работает с понедельника по воскресенье с 08:00 до 20:00 ч. Звонок бесплатный.

Ou kapab jwenn enfòmasyon sa yo gratis nan lòt lang. Rele nimewo 1-800-815-0000 oswa TTY/TDD 1-800-662-1220, lendi jiska dimanch, depi 8am jiska 8pm. Koutfil la gratis.

다른 언어로 작성된 이 정보를 무료로 얻으실 수 있습니다. 월요일 - 일요일 오전 8시부터 오후 8시 사이에 1-800-815-0000번이나 TTY/TDD 1-800-662-1220번으로 전화주세요. 통화는 무료입니다.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by GuildNet Gold Plus FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.