

Plan Name: FeelWell (HMO D-SNP)

Contract ID: H4922

Formulary ID: 22369

Plan ID: 003

Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, or upheld its decision regarding an at-risk determination made under its drug management program, you have the right to ask for an independent review of the plan's decision. **You may use this form to request an independent review of your drug plan's decision.** You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. You may submit your independent review request electronically at the Part D QIC Portal address below, or you may complete this form and mail or fax it to:

Standard Mail:

**C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
P.O. Box 44166
Jacksonville, FL 32231-4166**

Courier or Tracked Mail (e.g. FedEx or UPS):

**C2C Innovative Solutions, Inc.
Part D Drug Reconsiderations
301 W. Bay St., Suite 600
Jacksonville, FL 32202**

Toll Free Fax: (833) 710-0580

Web Portal Address: <https://www.c2cinc.com/Appellant-Signup>

Note about Representatives: Your prescriber may file a reconsideration request on your behalf without being an appointed representative. If you want another individual, such as a family member or friend, to request an independent review for you, that individual must be appointed as your representative.

Enrollee Information:

Enrollee Name: _____

Address: _____

City, State, Zip code: _____

Phone: (_____) _____

Medicare Number: _____

(From red, white and blue Medicare card)

Date of Birth (MM/DD/YYYY): _____

Name of current Part D Drug Plan: _____

Complete the following section ONLY if the person making this request is not the enrollee or the enrollee's prescriber (make sure to attach documentation showing the person's authority to represent enrollee for purposes of this request):

Representative's Name _____

Representative's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____

Prescription drug you asked your plan to cover:

Representation documentation for appeal request made by someone other than enrollee or prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination or redetermination level. A physician or other prescriber may request an appeal on behalf of the enrollee without being an appointed representative.

Prescribing Physician's or Other Prescriber's Information:

Prescriber Name: _____

Office Address: _____

City, State, Zip code: _____

Office Phone: (_____) _____

Office Fax: (_____) _____

Office Contact Person: _____

Expedited Decisions

If you or your prescribing physician or other prescriber believe that waiting for a standard decision (which will be provided within 7 days) could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician or other prescriber indicates that waiting 7 days could seriously harm your life or health or ability to regain maximum function, the independent review organization will automatically give you a decision within 72 hours. This timeframe may be extended for up to 14 calendar days if your case involves an exception request and we have not received the supporting statement from your doctor or other prescriber supporting the request, OR the person acting for you files an appeal request but does not submit proper documentation of representation. If you do not obtain your physician's or other prescriber's support for an expedited appeal, the independent review organization will decide if your health condition requires a fast decision.

Check this box if you believe you need a decision within 72 hours (if you have a supporting statement from your prescribing physician or other prescriber, attach it to this request)

Please attach any additional information you have related to your appeal such as a statement from your prescribing physician or other prescriber and relevant medical records. Please have your prescriber address the Plan's coverage criteria 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.

Additional information we should consider: _____

Important: Please include a copy of the Redetermination (denial) Notice that you should have received from your drug plan if available.

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

_____ **Date:** _____

AgeWell New York, LLC is a Health Maintenance Organization (HMO) plan with a Medicare contract. AgeWell New York, LLC has a State Medicaid Agency Contract with New York State Department of Health, and a New York State Medicaid contract for AgeWell New York Advantage Plus (HMO D-SNP). Enrollment in AgeWell New York, LLC depends on contract renewal. ATTENTION: If you speak Spanish, language assistance services are available to you free of charge. Call **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. ATENCIÓN: si hablas español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-237-3210 (TTY/TDD: 1-800-662-1220)**. Assistance services for other languages are also available free of charge at the number above.

Notice of Nondiscrimination

AgeWell New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AgeWell New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AgeWell New York provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact AgeWell New York Member Services at **1-866-237-3210**.

If you believe that AgeWell New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

AgeWell New York
Civil Rights Coordination Unit
1991 Marcus Avenue Suite M201
Lake Success, New York 11042-2057
1-866-237-3210
TTY/TDD: **1-800-662-1220**
Fax: **855-895-0778**

Email: civilrightsunit@agewellnewyork.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordination Unit is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, TTY/TDD: **1-800-537-7697**. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.