



## Request for Redetermination of Medicare Prescription Drug Denial

Because we My Choice Wisconsin Partnership 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:

My Choice Wisconsin Partnership  
Attn: Pharmacy Services  
1617 Sherman Ave  
Madison, WI 53704-5930

Fax Number:  
1-866-806-4134

You may also ask us for an appeal through our website at [www.mychoicewi.org/promptpa](http://www.mychoicewi.org/promptpa).

Expedited appeal requests can be made by phone at 1-800-963-0035.

**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.

Thank you,

My Choice Wisconsin Partnership

**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 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of person requesting the appeal (the enrollee, or the enrollee's prescriber or representative):**

\_\_\_\_\_ **Date:**

My Choice Wisconsin Medicare Dual Advantage and My Choice Wisconsin Partnership are HMO SNPs with a Medicare Advantage contract and a contract with the Wisconsin Department of Health Services for the Medicaid Program. Enrollment in Medicare Dual Advantage and Partnership depends on contract renewal.

This plan is available to anyone who has both Medical Assistance from the State and Medicare. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

This information is available for free in other languages or in an alternate format. Please call our customer service number from 8:00 AM to 8:00 PM Central / 7 days a week at 1-800-963-0035. TTY users should call Wisconsin Relay System 711.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.



### **Notice Informing Individuals About Nondiscrimination and Accessibility Requirements**

My Choice Wisconsin Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. My Choice Wisconsin Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

My Choice Wisconsin Health Plan:

- 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service.

If you believe that My Choice Wisconsin Health Plan 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:

My Choice Wisconsin Member Rights  
10201 West Innovation Drive Suite 100  
Wauwatosa, WI 53226

Toll-Free Phone Number: 1-800-963-0035  
TTY: Wisconsin Relay System 711  
Fax: (608) 246-8428  
Email: [mrs@carewisc.org](mailto:mrs@carewisc.org)

If you need help filing a grievance, our Member Rights Specialists are 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

Toll-Free Phone Number: 1-800-368-1019  
TDD: 800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Multi-language Interpreter Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-963-0035 (TTY users should call Wisconsin Relay System 711).

### Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-963-0035 (TTY: 711).

### Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-963-0035 (TTY: 711).

### Chinese

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 1-800-963-0035 (TTY: 711)。

### German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-963-0035 (TTY: 711).

### Arabic

1800-963-0035 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم هاتف الصم والبكم - (TTY: 711). (رقم

### Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-963-0035 (телетайп: 711).

### Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-963-0035 (TTY: 711)번으로 전화해 주십시오.

### Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-963-0035 (TTY: 711).

### Pennsylvanian Dutch

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-963-0035 (TTY: 711).

**Laotian**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-963-0035 (TTY: 711).

**French**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-963-0035 (TTY : 711).

**Polish**

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-963-0035 (TTY: 711).

**Hindi**

ध्यान दें : य • द आप • हदी बोलते ह • तो आपके िलए मुफ्त म • भाषा सहायता सेवाएं उपलब्ध ह। •  
1-800-963-0035 (TTY: 711) पर कॉल कर • ।

**Albanian**

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-963-0035 (TTY: 711).

**Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-963-0035 (TTY: 711).