

## **Request for Redetermination of Medicare Prescription Drug Denial**

Because we, Cigna-HealthSpring, 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:**

Cigna-HealthSpring  
ATTN: Part D Appeals  
PO Box 24207  
Nashville, TN 37202-4087

**Fax number:**

1-866-593-4482

You may also ask us for an appeal through our website at **[www.cignahealthspring.com](http://www.cignahealthspring.com)**. Expedited appeal requests can be made by phone at **1-866-845-6962**.

**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 \_\_\_\_\_

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 seven 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 seven 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.

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

Signature \_\_\_\_\_ Date: \_\_\_\_\_

This information is available for free in other languages. Please call our customer service number at 1-800-222-6700 (TTY 711), 8am - 8pm local time, 7 days a week. Our automated phone system may answer your call during weekends from Feb. 15 – Sept. 30. Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro servicio al cliente al 1-800-222-6700 (TTY 711), de 8 a.m. a 8 p.m., hora local, los siete días de la semana. Puede que nuestro sistema telefónico automático conteste sus llamadas durante los fines de semana del 15 de feb. al 30 de sept.

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