P.O. Box 266380
Weston, FL 33326

Plan Name: Farm Bureau Health Plans Contract ID: S2668

Formulary ID: 00021343 Version: 7

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. Please complete this form and mail or fax it to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 703
Pittsford, NY 14534-1302
Toll Free Fax: (866) 825-9507
Fax for Enrollees: (720) 462-7575

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 Beneficiary Identifier # _____
(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:** _____

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NONDISCRIMINATION AND ACCESS TO COMMUNICATIONS NOTICE

Members Health Insurance Company (MHIC) complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex. MHIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHIC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, Braille).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information in other languages.

If you need these services, contact Member Services at 1-866-643-6924, TTY 711, from 8AM to 8PM local time. Member Services is available Monday – Friday between April 1 – September 30 and 7 days a week between October 1 – March 30.

If you believe that MHIC 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:

Civil Rights Coordinator
P.O. Box 1801
Columbia, TN 38402-1801
Phone: 1-844-223-3451, TTY 711
Fax: 1-931-388-8326
Email: civilrights@fbhealthplans.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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, 800-537-7697 (TDD)

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

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-855-540-4744 (TTY: 711).

Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-540-4744 (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 1-855-540-4744 (TTY：711)

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-540-4744 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-540-4744 (TTY: 711)번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-540-4744 (телетайп: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-540-4744 (TTY: 711).

Arabic
ةظوحلم: مقرب لصتا .نانجملابا كلذ رفاوتت ةيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ 1-855-540-4744 (مقر

مكبلاو مصلا فتاه: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-540-4744 (ATS : 711).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-540-4744 (TTY: 711)تماس بگیرید.

Laotian
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-540-4744 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-540-4744 (TTY: 711).

Gujarati
□યુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-855-540-4744 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-540-4744（TTY: 771）まで、お電話にてご連絡ください。

Hindi
ध्यान द□: य□द आप □हदी बोलते ह □तो आपके िलए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-855-540-4744 (TTY: 711) पर कॉल कर□।

Turkish
DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-540-4744 (TTY: 711) irtibat numaralarını arayın.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-540-4744 (TTY: 711).

Amharic
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