

ABC Insurance Company

Notice of Denial of Medicare Part D Drug Coverage

Date:

Enrollee Name:

Member Number:

Your request was denied

We denied coverage or payment under Medicare Part D for the following prescription drug(s) that you or your prescriber asked for: Drug A

Why did we deny your request?

We denied this request under Medicare Part D because:

Drugs that are purchased by a prescriber and are administered in his or her office may be covered under Medicare Part B. Your Medicare Part D drug plan cannot cover a drug that is purchased by a prescriber and administered in his or her office.

This request was denied under your Medicare Part D benefit; however, it may be covered under Medicare Part A or Part B. For more information, talk to your prescriber or call 1-800-MEDICARE.

If you believe your Medicare Part D drug plan should have paid for this drug you may appeal our decision (see appeal information below).

You should share a copy of this decision with your prescriber and discuss next steps. If your prescriber asked for coverage on your behalf, we shared this decision with them.

Important Information About Your Appeal Rights

You have the right to appeal this decision

If you want to appeal, you must ask for an appeal within 65 calendar days of the date at the top of this notice. If you ask for an appeal after 65 days of the date on this notice, you must explain why your appeal is late.

You have the right to ask us for a **formulary exception** if you believe you need a drug that's not on our list of covered drugs (formulary). You have the right to ask us for a **coverage rule exception** if you believe a rule (like prior authorization or a quantity limit) shouldn't apply to you. You can either provide information that shows that you meet the coverage rule that applies to the drug you're asking for, or you can ask for a coverage rule exception. You can ask for a **tiering exception** if you believe you should get a drug at a lower cost-sharing amount. Your prescriber must provide a statement to support your exception request.

Who can ask for an appeal?

You, your prescriber, or your representative can ask for an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative. To learn how to appoint a representative, call us at: 800-335-3455. TTY users can call: 800-227-5688.

There are 2 kinds of appeals you can ask for

Expedited (72 hours): You can ask for an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You can't ask for an expedited appeal if you're asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we'll automatically expedite your appeal.**
- If you ask for an expedited appeal without support from your prescriber, we'll decide if your health requires an expedited appeal. If we don't give you an expedited appeal, we'll notify you and decide your appeal within 7 days.

Standard (7 days): You can ask for a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If your appeal is for payment for a drug you already received, we'll give you a written decision within 14 days.

How to ask for an appeal

For an Expedited (Fast) Appeal: You can ask for an appeal by phone, by fax, through the plan's website, or by mail. **A verbal request by phone is the fastest way to ask for an expedited (fast) request.**

Phone: 800-335-3455

TTY: 800-227-5688

For a Standard Appeal: You can file an appeal by phone, by fax, through the plan's website, or by mailing a letter to the address below.

Phone: 800-335-3455

TTY: 800-227-5688

Fax: 223-655-4655

Plan Website: ABCInsuranceCo.com

Address: ABC Insurance Company, 111 Main Street, Dayton, MD 21036

Here's what to include with your appeal request:

- Your name, address and member number
- The reasons you're appealing
- Any evidence you want to attach to support your case
- If you're asking for an exception to a coverage rule, your doctor must provide a supporting statement. Include information about why the coverage rule shouldn't apply to you because of your specific medical condition.
- If your appeal relates to a decision by us to deny a drug that's not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug, or would harm your health.

What happens next

After you appeal, we'll review your case and give you a decision. If any of the prescription drugs you asked for are still denied, you can ask for an independent review of your case by a reviewer outside of your Medicare drug plan. If you disagree with that decision, you'll have the right to further appeal. You'll be notified of your appeal rights if this happens.

Get help & more information

- ABC Insurance Company Toll Free: 800-335-3455 TTY users call: 800-227-5688
Monday-Friday 8:00 AM EST – 4:30 PM EST
ABCInsuranceCo.com
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050 (1-888-466-9050)
- Elder Care Locator: 1-800-677-1116
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1382 GenIC #9. This information collection is being conducted to help improve informational notices for people with Medicare and the results will be used to ensure that people with Medicare understand important information about their plans. The time required to complete this information collection is estimated to average less than 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is voluntary and CMS will keep the information private to the extent provided by law. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit

[Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more

information. TTY users can call 1-877-486-2048.