

# Today's Options® PPO

A WellCare Company

## Request for Redetermination of Medicare Prescription Drug Denial

Because Today's Options® PPO 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:  
Today's Options  
PO Box 31383  
Tampa, FL 33631

Fax Number:  
1-855-840-7315

You may also ask us for an appeal through our website at [www.TodaysOptionsPPO.com](http://www.TodaysOptionsPPO.com). Expedited appeal requests can be made by phone at 1-866-422-5009, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.

**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 Plan ID Number: \_\_\_\_\_

### Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

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: \_\_\_\_\_

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: \_\_\_\_\_

Today's Options® PPO is a Medicare Advantage plan with a Medicare contract. Enrollment in Today's Options® PPO depends on contract renewal.

Today's Options® PPO complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (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 1-888-736-7442 (TTY: 711)。