



Request for Redetermination of Medicare Prescription Drug Denial

Because we, Health Net, 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:
Health Net
Attn: Appeals & Grievances Dept.
P.O. Box 10450
Van Nuys, CA 91410-0450

Fax Number:
1-844-273-2671

You may also ask us for an appeal through our website at or.healthnetadvantage.com. Expedited appeal requests can be made by phone at 1-888-445-8913, TTY: 711.

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 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 and have your prescriber address the Plan's coverage criteria, if available, 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.

Signature of person requesting the appeal (the enrollee or the representative):_____
Date: _____

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

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

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-445-8913 (TTY: 711).

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net 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 by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center 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 (TDD: 1-800-537-7697).

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

Health Net is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Health Net depends on contract renewal.

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

| | |
|------------------------|---|
| SPANISH | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-445-8913 (TTY: 711). |
| CHINESE | 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-888-445-8913 (TTY: 711) |
| VIETNAMESE | CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi sẵn có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi 1-888-445-8913 (TTY: 711). |
| RUSSIAN | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-445-8913 (TTY: 711). |
| KOREAN | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-445-8913 (TTY: 711) 번으로 전화해 주십시오. |
| TAGALOG | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-445-8913 (TTY: 711). |
| UKRAINIAN | УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-445-8913 (TTY: 711). |
| JAPANESE | 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。1-888-445-8913 (TTY: 711) にお電話ください。 |
| MON-KHMER CAMBODIAN | ចំណាបអារម្មណ៍: បេសនអ្នកនយោបាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសារបង្កើត។ សូមទូរស័ព្ទទៅលេខ 1-888-445-8913 (TTY: 711) |
| ARABIC | تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-888-445-8913 (مكبلا و مصلا فتا ه مقرر: 711). |
| CUSHITE | XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-445-8913 (TTY: 711). |
| AMHARIC | ማስታወሻ የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-445-8913 (TTY: 711). |
| PUNJABI | ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-888-445-8913 (TTY: 711) ਤੇ ਕਾਲ ਕਰੋ। |
| GERMAN | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-888-445-8913 (TTY: 711). |

| | |
|----------|--|
| LAOTIAN | ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-445-8913 (TTY: 711). |
| ROMANIAN | ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-445-8913 (TTY: 711). |
| PERSIAN | توجه: اگر زبان شما فارسی است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-888-445-8913 تماس بگیرید. (TTY: 711) |
| FRENCH | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-445-8913 (TTY: 711). |
| THAI | เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-445-8913 (TTY: 711). |