MOLINA HEALTHCARE
Your Extended Family.

MI HEALTH LINK
Linking Medicare and Medicaid for you

Request for Redetermination of Medicare Prescription Drug Denial

Because we Molina Dual Options MI Health Link Medicare-Medicaid Plan 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:
7050 Union Park Center Drive, Suite 200
Midvale, Utah 84047

Fax Number:
(866) 290-1309

You may also ask us for an appeal through our website at MolinaHealthcare.com/Duals.
Expedited appeal requests can be made by phone at (855) 735-5604, TTY/TDD 711 Monday – Friday, 8 a.m. to 8 p.m., EST.

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:

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.*

_____
_____
_____
_____
_____

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

_____ ***Date:*** _____

Molina Dual Options MI Health Link Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

You can get this document for free in other formats, such as large print, braille, or audio. Call (855) 735-5604, TTY/TDD: 711, Monday - Friday, 8 a.m. to 8 p.m., EST. The call is free.

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Molina Healthcare of Michigan (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy and sex stereotyping.

To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language
  - Material that is simply written in plain language

If you need these services, contact Molina Member Services at (855) 735-5604; TTY/TDD: 711, Monday - Friday, 8 a.m. to 8 p.m., EST.

If you think that Molina failed to provide these services or treated you differently based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY, 711. Mail your complaint to:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (562) 499-0610.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

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English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-735-5604 (TTY: 711).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-5604 (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 1-855-735-5604（TTY：711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-735-5604 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-735-5604 (ATS : 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-735-5604 (TTY: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-735-5604 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-735-5604 (TTY: 711) 번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-735-5604 (телетайп: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-735-5604 (رقم هاتف الصم والبكم: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-735-5604 (TTY: 711) पर कॉल करें।

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-735-5604 (TTY: 711).

Portugués

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-735-5604 (TTY: 711).

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-735-5604 (TTY: 711).

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-735-5604 (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。1-855-735-5604（TTY: 711）まで、お電話にてご連絡ください。

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-735-5604 (TTY: 711).

Bengali

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-855-735-5604 (TTY: 711)।

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-735-5604 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Syriac (Assyrian language)

ܬܘܫܕܐ: ܐܢ ܐܦ ܥܠ ܦܘܡܟ ܠܫܢܐ ܐܬܘܪܝܐ، ܫܝܠ ܠܟ ܥܡ ܫܝܪܘܬ ܕܥܕܪܐ ܒܠܫܢܟ ܕܠܝܬ ܥܠܘܗܝ ܒܚܠܦ ܡܕܝ. ܩܪܝ ܠ 1-855-735-5604 (TTY: 711)