

Request for Redetermination of Medicare Prescription Drug Denial

Because we Molina Dual Options 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, UT 84047

Fax Number:

(866) 290-1309

You may also ask us for an appeal through our website at: MolinaHealthcare.com/Duals.

For more information on how to file a Grievance and Appeal please visit:

<http://www.molinahealthcare.com/members/sc/en-US/mem/duals/quality/gna/Pages/gna.aspx>

Expedited appeal requests (also can be referred to as “fast review” or “fast appeal”) can be made by phone at (855) 735-5831.

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.*

Member's Information

Member's Name _____ *Date of Birth* _____

Member's Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Member's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the member:

Requestor's Name _____

Requestor's Relationship to Member _____

Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Representation documentation for appeal requests made by someone other than member or the member's prescriber:

Attach documentation showing the authority to represent the member (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 member, or the Member's prescriber or representative):

Date: _____

Molina Dual Options Medicare-Medicaid Plan is a health plan that contracts with both Medicare and South Carolina Healthy Connections 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) 735-5831, TTY/TDD: 711, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free.

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Molina Healthcare of South Carolina (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) 735-5831; TTY/TDD: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

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.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-735-5831 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-735-5831 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-735-5831 (رقم هاتف الصم والبكم: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-735-5831 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-735-5831 (телетайп: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-735-5831 (TTY: 711).
Brazilian Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-735-5831 (TTY: 711).
Mandarin	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 1-855-735-5831 (TTY: 711)。
Falam	RALRINNAK: Falam (Laizo) `ong na thiam asile, man lo tein `onglettu bawmh le hna`uan seknak nangmah hrangah aum. ah ko aw 1-855-735-5831 (TTY: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-735-5831 (TTY: 711) पर कॉल करें।
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-735-5831 (TTY: 711) 번으로 전화해 주십시오.
Chin	THEIHDING: Lai holh na thiam asi ah cun, holh let tu a lak in kan in hlan piak lai. 1-855-735-5831 (TTY: 711) ah in rak hlat te.
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-735-5831 (TTY : 711).
Karen	ဟ်သး-နမ့ၢ်ကတိၤကညိၣ်ကျိၣ်,ကျိၣ်အတၢ်ဆိၣ်ထွဲမၤစၢၤအတၢ်ဖိးတၢ်မၤတဖၣ်,တၢ်ဒီးန့ၢ်ဟ့ၣ်ကလိတဖၣ်န့ၢ်ဝဲဒၣ်လၢနဂီၢ်. ကိးယီၤ (၁-၈၅၅-၇၃၅-၅၈၃၁) (TTY:၇၁၁).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-735-5831 (መስማት ለተሳናቸው፡ 711)፡፡
Burmese	သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-855-735-5831 (TTY: 711) သို့ ခေါ်ဆိုပါ။