Medical & Part D Appeal Request Form

If you disagree with the decision for a request for coverage or payment for a service, you have the right to ask us for a reconsideration/redetermination (appeal) of our decision. You have 60 days from the date of our notice of denial to ask us for an appeal. You may also ask us for an appeal through our website. For assistance with this form or questions regarding your appeal, please contact our Customer Service department at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. PST.

Who May Make a Request: In addition to you**,** your physician/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. To appoint another person to act as your representative, contact Customer Service and request an "Appointment of Representative" form.

Please mail or fax completed form to:

Fax: 1-866-339-8751

Appeals and Grievances
2965 Ryan Drive SE
Salem OR 97301

Important Note: Expedited Decisions

Medical Item/Service - If you believe that waiting 30 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. You cannot request an expedited appeal if you are asking us to pay you back for a service/item you already received.

Medicare Prescription Drug - If you believe that waiting 7 days for a standard prescription drug decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS.
Expedited appeal requests can also be made by phone at: **1-877-672-8620** (TTY 711), daily from 8 a.m. to 5 p.m. PST.

Member Name:	ID#:	DOB:
Representation documentation for appeal requests made by someone other than enrollee or the enrollee's physician: Attach documentation showing the authority to represent the enrollee (a completed Appointment 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 (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users can call 1-877-486-2048.		
Requestors Name (if other than member):		
Relationship to member:		
If representing the member, the first 3 lines of information should be your information.		

Address:		
City:	State:	Zip:
Telephone #:		
What you are appealing:		
Reference/Claim #:		
Date of Service (if applicable):	Date of Decision Notice:	
For Part D Requests, fill in the below 5 lines		
Prescriber Name:	Office phone:	
Name of drug:	Strength/quantity/dose:	
Have you purchased the drug pending appeal? Yes No		
If “yes” - Date Purchased:	Amount paid: (attach a copy of receipt)	
Name and telephone number of pharmacy:		

Please indicate the reason for the Medical or Part D appeal (is there additional information we should consider when reviewing this appeal?):*

Requestor's Signature:* **Date of Signature:*** **Time of Signature:***