

## Request for Redetermination of Medicare Prescription Drug Denial

Because we Central Health Medicare 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:	Fax Number:
Central Health Medicare Plan	(626) 388-2368
1540 Bridgegate Dr.	
Diamond Bar, CA91765	

You may also ask us for an appeal through our website at [www.centralhealthplan.com](http://www.centralhealthplan.com). Expedited appeal requests can be made by phone at (626) 388-2390.

**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**

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Enrollee's Name

Date of Birth

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Enrollee's Address

H5649\_112211\_3001\_RD File & Use 11272011



**Prescription drug you are requesting:**

\_\_\_\_\_

**Name of drug:** \_\_\_\_\_

**Strength/quantity/dose:**

Have you purchased the drug pending appeal?  Yes  No

If "Yes": \_\_\_\_\_

H5649\_112211\_3001\_RD File & Use 11272011

**Date purchased:**

**Amount paid: \$**



**Prescriber's Information**

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Name

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Address

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City  
H5649\_H2211\_3001\_RD File & Use 11272011

State

**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.

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

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**Date:**