

Prescription Drug Redetermination (Appeal) Form Instructions

This form may be used to request a redetermination (appeal) of a denied service or coverage determination. Note: You must have received a denied coverage determination before you can request a redetermination (appeal). Please see Coverage Determination form if you need to request a coverage determination first.

To request a standard redetermination, the enrollee or the enrollee's representative must file a written request with the Part D Plan, or an oral request, within 60 calendar days from the date of the notice of the coverage determination. Note that the prescribing physician may not appeal on behalf of the enrollee for a standard redetermination request; the prescribing physician who wishes to appeal in this circumstance must appeal as a representative and must first complete the Appointment of Representative form.

Please complete all of the member and denied coverage determination information. Be sure to include your reason for appeal and any supporting documentation.

If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) we will give you a decision within 72 hours. If you do not obtain your physician's support we will decide if your health condition requires a fast decision.

Mail:

ODS Health Plan, Inc.
Attn: ODS Advantage –Redetermination
P.O. Box 40384
Portland OR 97240

(503) 243-5105 FAX

Deliver:

ODS Health Plan, Inc.
601 S.W. Second Ave. 7th Floor
ODS Advantage Healthcare Services
Portland, OR 97204

You can call Member Services if you would like to request a redetermination orally, if you would like a fast decision or if you need help with this form, call us Monday through Sunday from 8:00 am until 8:00 pm Pacific time.

Pharmacy Customer Services:

1-888-786-7509
1-800-433-6313 TTY

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____
2. Medicare Number: _____
3. Description of Item or Service in Question: _____
4. Date the Service or Item was Received: _____
5. I do not agree with the determination of my claim. MY REASONS ARE:

6. Date of the initial determination notice _____
(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

7. Additional Information Medicare Should Consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Beneficiary: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.