

Medicare Advantage



South Carolina

BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association

Request for Redetermination of Medicare Prescription Drug Denial

Because BlueCross BlueShield of South Carolina 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:
OptumRx
Prior Authorization Department
P.O. Box 25184
Santa Ana, CA 92799

Fax Number:
1-877-239-4565

Expedited appeal requests can be made by phone at 1-888-645-6025. TTY users should call 711. October 1 - March 31, Customer Service hours are 8 a.m. - 8 p.m., seven days a week; April 1 - September 30, Customer Service hours are 8 a.m. - 8 p.m., Monday – Friday.

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 Representative 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 _____

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.

If you have a supporting statement from your prescriber, attach it to this request.

[illegible]

Date: _____