Request for Redetermination of Medicare Prescription Drug Denial

Because we Vibra Health 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:
Vibra Health Plan Attn: Clinical Review Department 1305 Corporate Center Drive Eagan, MN 55121	1-800-693-6703

You may also ask us for an appeal through our website at vibrahealthplan.com.
Expedited appeal requests can be made by phone at 1-855-457-1352, TTY 711, 24 hours a day/7 days a week.

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 ____________________________

<u>Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:</u>

Attach documentation showing the authority to represent the enrollee (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.

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

____ **Date:** _____________

Vibra Health Plan is a PPO plan with a Medicare contract. Enrollment in Vibra Health Plan depends on contract renewal.

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Vibra Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Vibra Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Vibra Health Plan provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓Qualified sign language interpreters
- ✓Written information in other formats (large print, audio, accessible electronic format, other formats)
- ✓Qualified interpreters, and information written in other languages

If you need these services, call 1-844-388-8268 (TTY: 711).

If you believe that Vibra Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person; or you can file a grievance by mail, phone, fax, or email at:

Vibra Health Plan
P.O. Box 60250 Harrisburg, PA 17106-0250
1-717-510-6203 (TTY: 711), fax, 1-844-744-5585
CRC@vibrahealthplan.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance
To talk to an interpreter in your language at no cost, call 1-844-388-8268 (TTY: 711).
Para hablar con un intérprete de forma gratuita, llame al 1-844-388-8268 (TTY: 711).
欲免费用本国语言洽询传译员，请拨电话 1-844-388-8268 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 1-844-388-8268 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 1-844-388-8268 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 1-844-388-8268 uff (TTY: 711).
무료 전화 통역 서비스 1-844-388-8268 (TTY: 711).
Per parlare con un interpete nella vostra lingua gratis, chiami 1-844-388-8268 (TTY: 711).
للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 1-844-388-8268 (الهاتف النصي: 711)
Pour parler à un interpréter dans votre langue sans charges, téléphoner à 1-844-388-8268 (TTY: 711).
Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-388-8268 an (TTY: 711).
દુભાષીયા જોડે વાત કરવા, 1-844-388-8268 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 1-844-388-8268 (TTY: 711).
Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 1-844-388-8268 (TTY: 711).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 1-844-388-8268 (TTY: 711).
Para falar com um intérprete em seu idioma de graça, ligue para 1-844-388-8268 (TTY: 711).