

Request for Redetermination of Medicare Prescription Drug Denial

Because we [Part D plan sponsor] 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:

EnvisionRx Options
2181 East Aurora Rd
Suite 201
Twinsburg, OH 44087

Fax Number:
1-877-503-7231

You may also ask us for an appeal through our website at www.brighthouseplan.com. Expedited appeal requests can be made by phone at 1-833-665-5346.

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 Member 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 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 and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Signature of person requesting the appeal (the enrollee or the representative):_____
Date: _____



Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright Health plans and their affiliates.

Language assistance and alternate formats:

Assistance is available *at no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call the Member Services number on your member ID card.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
PO Box 853943, Richardson, TX 75085-3943
Phone: (844) 202-2154
Email: OAG@brighthealthplan.com

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call the Member Services number on your member ID card. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the Member Services number on your member ID card.

English	ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call the Member Services number on your ID card.
Spanish (US)	ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación.
Chinese (S)	注意：如果您讲中文，我们可以为您提供免费的语言协助服务。请拨打您ID卡上的会员服务电话号码。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните в Службу работы с клиентами по телефону, указанному в Вашей идентификационной карте.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. ID 카드에 있는 회원 서비스 번호로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm nan nimewo ki make sou kat ID ou an.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero dell'assistenza ai membri riportato sulla Sua scheda identificativa.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט יידיש, עס זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט די מעמבער סערוויסעס נומער אויף אייערע איידי קארטל.
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে আপনার জন্য, ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে উপলব্ধ আছে। আপনার ID কার্ডে থাকা সদস্য পরিষেবাগুলির নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فيمكنك الاستعانة بخدمات المساعدة اللغوية بدون مقابل. اتصل برقم خدمات الأعضاء المدون على بطاقة التعريف الخاصة بك.
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić do Działu Usług dla Członków, którego numer jest podany na Pana/ Pani karcie identyfikacyjnej.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le numéro des services aux membres, qui figure sur votre carte d'identification.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo para sa wika. Tawagan ang numero ng Mga Serbisyo sa Miyembro na nasa inyong ID kard.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số Dịch vụ Hội viên trên thẻ ID của quý vị.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí Diné bizaad be yáníłti'go, saad bee áká'ánida'áwo' déé', t'áá jiik'eh, ná hóló. Kojí' hódíłnih Member Servicesjí éí binumber naaltsoos nitł'izgo bee nee hódółzin biniyé nantinígíí bikáá'
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ اپنے آئی ڈی کارڈ پر موجود ممبر سروسز کے نمبر پر کال کریں۔
Japanese	注記: 日本語をお話しになる方は、無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載のメンバーサービス電話番号までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para o número de Atendimento ao Associado, impresso no seu cartão de identificação.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter der auf Ihrer ID-Karte aufgeführten Telefonnummer für Mitgliederdienstleistungen an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات کمک زبانی به صورت رایگان در اختیار شماست. با «خدمات اعضا» که شماره آن روی کارت شناسایی شما درج شده است تماس بگیرید.

Amharic	ማሳሰቢያ፡ ከአንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆኑ የቋንቋ ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ። በመታወቂያ ላይ በሚገኝ የአባላት አገልግሎት ቁጥር ላይ ይደውሉ።
Burmese	သင့်သည့် အင်္ဂလိပ်စကားမဟုတ်သော အချားဘာသာစကားတစ်ခုအား ဂျပန်လိုသူဖြစ်ပါက ဘာသာစကားအခွဲပိုင်းသည့် ဝန်ဆောင်မှုများအား သင့်ရရှိနိုင်ပါသည်။ သင့် ID (သက်သေခံ) ကတ္တလေးပေါ်၌ အဖော်ပြုဝင်မှားဝန်ဆောင်မှုဌာနအား ဖုန်းခေါ်ဆိုပါ။ 𑜀𑜃𑜫𑜄𑜇𑜂𑜫: ꠔꠕ ꠌ𑜏𑜤𑜃𑜫 𑜂𑜫𑜏𑜤 bꠟ ꠦꠞ𑜀, ꠌ𑜏𑜤𑜃𑜫𑜄𑜇𑜂𑜫 ꠙꠤ𑜂ꠦꠤꠟ ꠗꠕ𑜂ꠦꠤꠟ, ꠘ ꠗ𑜂𑜫 ꠙꠤꠒꠤ 𑜂𑜫 ꠙꠙ𑜂ꠦꠤ, h𑜁 ꠕꠒ𑜂𑜫𑜂𑜫𑜂𑜫𑜂𑜫𑜂𑜫. 𑜂𑜫𑜂𑜫𑜂𑜫 𑜂𑜫𑜂𑜫 𑜂ꠤ ꠙꠤ𑜂ꠦꠤ𑜂𑜫 𑜂𑜫𑜂𑜫 𑜂𑜫𑜂 ꠕꠤ ꠗꠤ𑜂𑜫 𑜂𑜫𑜂𑜫.
Cherokee	
Cushite-Oromo	XIYYEEFFANNOO: Afaan Ingiliziin ala afaan kan biraa kan dubbattu yoo ta’e, tajaajilliiwwan gargaarsa afaanii, kan tolaa, siif ni jiru. Kaardii Waraqaa-eenyummeessaa keerra kan jiru lakkoofsa Tajaajilawwan Miseensaatti bilbili.
French Creole	ATANSYON : Si w pale yon lòt lang ke Angle, gen sèvis èd lengwistik ki disponib pou w gratis. Rele nimewo Sèvis pou manm yo nan kat idantite w la.
Gujarti	ધ્યાન આપોઃ જો તમે અંગ્રેજી સિવાયની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે ભાષા સહાય સેવાઓ નિઃશુલ્ક ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર રહેલા સંદર્ભની સેવાઓનાં નંબર પર કૉલ કરો.
Hindi	ध्यान दें: यदि आप अंग्रेजी के अलावा कोई अन्य भाषा बोलते हैं, तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। आपके आईडी कार्ड पर दिए गए सदस्य सेवा नंबर पर कॉल करें।
Hmong	UA ZOO SAIB: Yog tias koj hais ib hom lus dhau ntawm lus As Kiv, muaj cov kev pab cuam txhais lus uas tsis xam nqi dab tsi rau koj tau siv. Hu rau Lub Chaw Pab Cuam Tswv Cuab tus nab npawb xov tooj nyob ntawm koj daim npav ID.
Karen	တီၢ်နီၣ် - န့ၣ်ကတီၢ်ကျိၣ်လၢတၢ်ဆဲးကလံးကျိၣ်ဘၣ်န့ၣ်, ကျိၣ်တၢ်တီၢ်စၢၤမၤစၢၤတၢ်မၤစၢၤတဖၣ်, လၢတလိၣ်ဟ့ၣ်အပူၤတဖၣ်ဆိၣ်လၢနီၣ်န့ၣ် လီၤ. ကိးကရၢဖိတၢ်မၤစၢၤတဖၣ် (န့ၣ်ဘၣ်န့ၣ်မ့ၣ်မလငါ) အနီၣ်ဂံၢ်ဝဲန တၢ်အုၣ်သးနီၣ်ဂံၢ်ဝဲက့ၢ်အဖီခိၣ်န့ၣ်တက့ၢ်.
Kru / Bassa	YI LE: I balé u mpot hop umpè èbes Ngissi, bot ba nhola ni kobol mahop bayé ha i nyuu yoñ, ngui nsaa wogui wo. Sebel Ndap Mahola i nyuu Mbon i nsinga i yé ntilgaga munu i Kat yon i Mbon.
Kurdish	ئاگاداری: ئەگەر بە زمانێکی تری جگە لە ئینگلیزی قسە دەکەیت، خزمەتگوزاریه زمانهوانیهکان بهخۆراپی بۆ تو به‌دهستن. پهیوهندی به ژماره‌ی خزمەتگوزاری ئەندامانی سهر ناسنامەکەت بکه.
Laotian	ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ ເສຍຄ່າແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາ ໝາຍເລກການບໍລິການສະມາຊິກທີ່ຢູ່ເທິງ ບັດ ID ຂອງທ່ານ.

