**Request for Redetermination of Medicare Prescription Drug Denial**

Because we 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 email or mail.

**Address:**
Health Pointe of New York, LLC
PO Box 5265
Hauppauge, NY 11788

**Email Address**: HPNY_Appeals@healthpointeny.com

Expedited appeal requests can be made by telephone:

H1722 (**844-269-3442**/TTY 711)
H5989 (**888-201-4342**/TTY 711)

**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: Enrollee's Birthday:
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 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.**

Health Pointe of New York

**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 Number:

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 hour. 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. Attachments may be mailed or faxed.

**DO YOU BELIEVE THAT YOU NEED A DECISION WITHIN 72 HOURS?** Yes No

**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 enrollee's prescriber or representative):**

Date:

Health Pointe
of New York

***Health Pointe Direct Complete Plan (HMO SNP) is required by federal law to provide the following information.***

Health Pointe Direct Complete Plan (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Health Pointe Direct Complete Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Health Pointe Direct Complete Plan provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the Customer Care Center at 1-844 269-3442.

If you believe that Health Pointe Direct Complete Plan (HMO SNP) 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. If you need help filing a grievance, The Grievance Department is available to help you. You can file a grievance in person or by mail, fax, or email:

Grievance Department
810 7th Ave, Suite 801
New York, NY 10019
Phone: 1-844-269-3442
Email: Grievance@healthpointeny.com

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
1-800-368-1019, 800-537-7697 (TDD)

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

Health Pointe
of New York

# Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-844 269-3442. Someone who speaks English/Language can help you. This is a free service.

**Language Assistance:**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844 269-3442 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844 269-3442（TTY：711）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844 269-3442 (телетайп: 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844 269-3442 (711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844 269-3442 (711)번으로 전화해 주십시오.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-844 269-3442 (711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-844 269-3442 (TTY: ১711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844 269-3442 (711).

Health Pointe
of New York

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844 269-3442(رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844 269-3442 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844 269-3442 (711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844 269-3442 (711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-844 269-3442 (711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844 269-3442 (711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-844 269-3442 (711).