Steps to Follow to Get Your Medicare Prescription(s) Filled

Step 1: Getting Started

Write down the following information:

- The name(s) of the prescription drug(s) and dose(s) that you believe you need.

Drug name and dose: ________________________ ________________________

Drug name and dose: ________________________ ________________________

- The name and phone number of the pharmacy that told you the prescription drug(s) is/are not covered by your Medicare PDP.

Name: __________________________ Phone: (____) ____________________

- The date you were told that the prescription drug(s) is/are not covered.

Date: ____ /____ /____

Step 2: Exceptions

Call your Medicare PDP, ask for an explanation of why the prescription is not covered (coverage determination), and request an exception at this time if you need a drug that is not on your plan's formulary or you need a drug at a lower co-payment.

Your plan may require an oral or written supporting statement from your doctor to demonstrate that you need the drug(s). Write down the following:

Reasons why drug(s) denied: ____

Does my doctor need to be involved? Yes / No (Circle one)

If yes, how? ____

Next steps I need to take: ____

Step 3: Appeals

If your exception request is denied, review your plan's benefit materials (Evidence of Coverage), then contact your plan to learn more about how to appeal the decision. We have attached a sample appeal letter you may use to submit the appeal in writing. You may need to follow up with your doctor's office during the appeals process for more information and/or to get an expedited review.

Here are some additional resources:

- **1-800-MEDICARE,** the official Medicare hotline for personalized assistance for people with Medicare, has phone lines open 24/7.
- **www.medicare.gov** is the official Medicare Web site. Go to **www.medicare.gov/publications/pubs/pdf/11112.pdf** for information on how to file a coverage determination or appeal.

Remember, the Medicare drug benefit is a voluntary program, and each year you have the right to choose the plan that's right for you.

Live well. Age well.

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Step 3: Instructions for Writing an Appeal Letter When Your Exception Is Denied

We have included a sample appeal letter* on the reverse side that you may use to start the appeals process. Please fill in the information using the directions below as a guide. Then tear off the sheet and fax or mail it to your Medicare PDP.

Today's Date _____/_____/_____

Patient Name ________________________________

Patient Address ________________________________

City ____________________ State ___ ZIP ________

Patient Phone Number (_____) ________________

Patient ID Number ________________________________

Patient Date of Birth ________________________________

____
Health or prescription plan name

Plan Address ________________________________

City ____________________ State ___ ZIP ________

To Whom It May Concern:

I am writing to appeal denial of drug coverage. I am covered under your plan and my ID number is __________ (ID number). On ________ (date), I attempted to fill a prescription for ________________ (name of medicine) at the ____________________ (pharmacy name) Pharmacy located at ________________________________ (pharmacy address).

I was told by the pharmacist that ________________________________ (reason for denial).

I decided to ________________________________ (action taken). My contact information is above, and contact information for Dr. ________________________ (name of doctor who wrote prescription) is listed below if specific medical information is needed for consideration of my appeal.

Doctor's Address ________________________________

City ________________ State ___ ZIP______ Doctor's Phone Number (_____) ____________

I have included a copy of the ______________ (prescription or receipt) for your consideration.

Please provide me with a written explanation of any additional steps I must take for you to process my appeal, as well as a written explanation of the basis for your decision about my claim.

I look forward to receiving a timely decision on this request.

Sincerely,

____
your signature

This information is on the back of your pharmacy benefit ID card.

Your ID number is on the front of your pharmacy benefit ID card.

For example, did you pay for the medicine yourself? Did you decide to not fill the prescription?

If you don't have a copy of the written prescription or the pharmacy receipt, list the name of the medication and the dose that you were prescribed. If necessary, ask your pharmacist for help.

**This sample appeal letter is provided for informational purposes only. Every Medicare prescription drug plan has its own rules and procedures for appeals, and this sample letter may not meet the requirements of your plan. DO NOT USE THIS LETTER WITHOUT FIRST CHECKING THE SPECIFIC PROCEDURES OF YOUR PLAN FOR APPEAL LETTERS. Please note: You may need information from your doctor to complete the letter.*

Today's Date _____/_____/_____

Patient Name ___________________________________

Patient Address _________________________________

City ______________________ State ___ ZIP ________

Patient Phone Number (_____) ____________________

Patient ID Number _______________________________

Patient Date of Birth _____________________________

____
Health or prescription plan name

Plan Address ____________________________________

City ______________________ State ___ ZIP ________

To Whom It May Concern:

I am writing to appeal denial of drug coverage. I am covered under your plan and my ID

number is ___________ (ID number). On ________ (date), I attempted to fill a prescription for __________________ (name of medicine)

at the _____________________ (pharmacy name) Pharmacy located at ______________________________________ (pharmacy address).

I was told by the pharmacist that ____ (reason for denial).

I decided to ____ (action taken). My contact information

is above, and contact information for Dr. ____________________________ (name of doctor who wrote prescription) is listed below if specific

medical information is needed for consideration of my appeal.

Doctor's Address ____

City ___________________ State ___ ZIP______ Doctor's Phone Number (_____) ______________

I have included a copy of the ________________ (prescription or receipt) for your consideration.

Please provide me with a written explanation of any additional steps I must take for you to process

my appeal, as well as a written explanation of the basis for your decision about my claim.

I look forward to receiving a timely decision on this request.

Sincerely,

____
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