

Appeal of Denial of Request for Prescription Drug Coverage

You have the right to ask us for a redetermination (appeal) of our decision. You have 180 days from the date of our Notice of Denial of Prescription Drug Coverage to ask us for a redetermination or appeal. The enclosed form may be sent to us by mail, email, or fax:

NORTHWIND HEALTH COMPANY
4838 FLETCHER AVENUE
INDIANAPOLIS, IN 46203

Telephone: 800-722-0772

Fax: (317) 653-1113

Email: pa@northwindhealth.com

Hours of Operation: Monday-Friday 8:00AM-5:30PM EST

Who May Make a Request:

You may ask or 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 legal representative.

WHAT OTHER IMPORTANT INFORMATION SHOULD I KNOW?

There are two types of redeterminations or appeals you can request:

1. Standard or non-urgent (up to 30 days):

You, your prescriber, or your legal representative may request a standard appeal. We must give you a decision within 30 days of receiving the appeal.

2. Urgent/Expedited (72 hours):

You, your prescriber, or your legal representative may request an urgent or expedited appeal if you or your prescriber believe that your health may be at serious risk by waiting up to up to 14 days for a decision. You may not request an expedited appeal if you have already obtained the medication being requested. If the request to expedite the appeal is granted, we must give you a decision within 72 hours of receiving the appeal.

WHAT HAPPENS AFTER I SUBMIT THE APPEAL?

There are two levels of redeterminations or appeals:

- + **Appeal Level 1** - You may ask us to review coverage denial we've issued to you, even if only part of our decision is not what you requested. A review will be conducted by a Northwind Appeals Reviewer. A point of contact will be appointed for you, your prescriber, or your legal representative. This person will notify you of the decision of the committee.
- + **Appeal Level 2** - If we reviewed your appeal at "Appeal Level 1" and did not decide in your favor, you may request a second level appeal. This appeal will be sent to an Independent Review Organization (IRO) for an external review of your Request for Prescription Drug Coverage. Instructions on how a level 2 appeal is processed will be included in your response for the level 1 appeal.

The appeal form listed below must be completed in full. Incomplete forms will delay the appeals process.

HOW DO I REQUEST THE APPEAL?

Submit the form included in this letter and any supporting documentation to the address, email, or fax listed above.

Enrollee's Information				
Enrollee's Name:		DOB:		
Enrollee's Address:				
City:		State:		Zip Code:
Phone:		Enrollee's Member ID Number:		

Complete the Requestor's Information Section below ONLY if the person making this request is not the enrollee. Otherwise, skip to the Prescriber's Information Section:

Requester's Information			
Requestor's Name:		Requestor's Relationship to Enrollee:	
Address:		City:	
State:		Zip Code:	
State:		Phone:	

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 up to 14 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 up to 14 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 Prescription Drug Coverage.

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

Date: