

**PART D QIC RECONSIDERATION  
CASE FILE TRANSMITTAL FORM**

Name of Part D Plan: \_\_\_\_\_

Date of Redetermination Notice: \_\_\_\_\_

**Appeal Information:** (Check one for each line)

- a. Priority:       Expedited       Standard  
 b. Appeal Type:       Prospective       Retrospective  
 c. Auto-forward:       Yes       No

<b>Appellant Name</b>	<b>Enrollee Name</b>

<b>Enrollee HIC/Medicare Claim Number</b>	<b>Date of Birth</b>

**Enrollee Address and Phone Number:**

**Part D Plan Information:**

Plan Type:    PDP (S#)    MA-PD (H or R#)    Cost

Plan Contract# (H/S/R) \_\_\_\_\_ (Circle "H" "S" or "R" and list the 4 digit CMS Plan Contract #)

Plan ID # \_\_\_\_\_      Formulary Name/Formulary ID # \_\_\_\_\_

Plan Contact (Name/Title) \_\_\_\_\_

Phone # \_\_\_\_\_      Fax # \_\_\_\_\_      Email \_\_\_\_\_

Plan Address \_\_\_\_\_

\_\_\_\_\_

**Representative Appeals:** (**\*\*\*NOTE: Representative documents MUST be included in case file\*\*\***)

Name of Representative \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_      Fax # \_\_\_\_\_      Email \_\_\_\_\_

**PLAN ATTESTATION FOR VALIDITY OF REPRESENTATIVE**

*I attest on behalf of the Part D Plan sponsor that the above referenced representative appealed at the Plan level and is a valid representative of the enrollee under State law.*

Signed \_\_\_\_\_      Print Name \_\_\_\_\_

Requested coverage at CD level       Appealed at RD level

*\*If multiple drugs in dispute, print and complete a separate version of this page for each drug in dispute*

**Plan Level Appeal Information:**

**Coverage Determination (CD):**

Date Requested: \_\_\_\_\_ Decision Date: \_\_\_\_\_ Was CD Timely?  YES  NO

Did Appellant Ask Plan To Expedite?  YES  NO Did Plan Expedite?  YES  NO

**Redetermination (RD):**

Date Requested: \_\_\_\_\_ Decision Date: \_\_\_\_\_ Was RD Timely?  YES  NO

Did Appellant Ask Plan To Expedite?  YES  NO Did Plan Expedite?  YES  NO

**For Determinations Involving an Exceptions Request:**

Is the Prescribing Physician Statement in the Case File?  YES  NO

**Drug Benefit in Dispute:**

Name of Drug: \_\_\_\_\_

Quantity/Dosage (e.g. 20 mg BID) \_\_\_\_\_

Is Prescriber Requesting:  Brand  Generic  Either Acceptable (Check one)

Off-Formulary?  Yes  No

**Pre-Service Requests:** Has Enrollee Purchased the Drug Pending Appeal?  Yes  No

If YES: Date Purchased: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Purchased From Network Pharmacy?  Yes  No.

**Retrospective Requests:** Date(s) of Purchase: \_\_\_\_\_

Amount(s) Paid: \_\_\_\_\_ Drug Tier: \_\_\_\_\_

Purchased From Network Pharmacy?  Yes  No.

If NO, explain: \_\_\_\_\_

**Drug Benefit Denial Rationale:**

- |  |  |
|--|--|
| <input type="checkbox"/> PA rules not met                | <input type="checkbox"/> Step Therapy exception rules not met                    |
| <input type="checkbox"/> Dose/QL exception rules not met | <input type="checkbox"/> Brand/Generic Cost Differential exception rules not met |
| <input type="checkbox"/> PA exception rules not met      | <input type="checkbox"/> Off-Formulary exception rules not met                   |
| <input type="checkbox"/> Tiering exception rules not met | <input type="checkbox"/> Out-of-Network rules not met                            |
| <input type="checkbox"/> Excluded Drug Class/Use         | <input type="checkbox"/> Covered Under A/B                                       |
| <input type="checkbox"/> Cost-Sharing Dispute            | <input type="checkbox"/> Not a Medically Accepted Indication                     |
| <input type="checkbox"/> Other _____                     |  |

**Prescriber Information:**

Name/Specialty of Physician \_\_\_\_\_

Office Address \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

Prior Authorization Form Submitted?  Yes  No

Exhibits: Label applicable exhibits with letters provided below, and place them in order by letter.	
<b>Procedural Documents</b>	<input type="checkbox"/> <b>A.</b> Case Narrative cover page that presents an overview of the appeal: Describe the issue on appeal; Identify all relevant information; Identify the arguments presented in favor of coverage; and Explain the Plan rationale for denial. <input type="checkbox"/> <b>B.</b> Request for Coverage Determination and Plan Coverage Determination Decision Notice <input type="checkbox"/> <b>C.</b> Request for Redetermination and Plan Redetermination Decision Notice <input type="checkbox"/> <b>D.</b> Prescribing Physician Statement (for exceptions requests) <input type="checkbox"/> <b>E.</b> Representation Documents (AOR or other writing, DPOA/POA, Healthcare Proxy, Surrogate for an incompetent enrollee under State law, estate representative) <input type="checkbox"/> <b>F.</b> Other (describe or list additional exhibits the Plan considers important)
<b>Evidentiary Documents</b>	<input type="checkbox"/> <b>G.</b> Part D Plan Formulary (relevant exceptions and/or coverage criteria) <input type="checkbox"/> <b>H.</b> Part D Plan Evidence of Coverage or other Subscriber Materials (relevant portions) <input type="checkbox"/> <b>I.</b> Cost Sharing Information (copies of internal Plan documents/screens showing TrOOP or other cost-sharing information as relevant to the dispute). <input type="checkbox"/> <b>J.</b> Medical Records (separated by physician, labeled, and in chronological order with most recent on top). <input type="checkbox"/> <b>K.</b> Medicare Rules (Medicare law and regulations, CMS manuals, and/or CMS program guidance as relevant to the Part D Plan's determination). <input type="checkbox"/> <b>L.</b> Redetermination Evidence (evidence submitted by appellant and/or the prescribing physician, and internal Plan medical reviews conducted to evaluate medical necessity issues) <input type="checkbox"/> <b>M.</b> Other (describe or list additional exhibits the Plan considers important).