Medicaid Medication Appeal Request Forms

Because <WellCare> Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to an appeal. The means you may ask us to review our decision. You have <All except CHP & BHP: 60 days, CHP: 45 days, BHP: 180 days> from the date of our Notice of Adverse Benefit Determination to ask us for an appeal. To start the appeal, please fill out this form and send it to us by mail or fax:

<WellCare of North Carolina>
<P. O. Box 31383
Tampa, FL 33631>
<Fax Number: 1-866-388-1766>

If you have question about this form, please call Customer Service at <**1-866-799-5318>** (**TTY: 711**) Monday–Saturday, 7am to 6pm.

You may also ask us for an appeal through our website at <**www.wellcare.com**>.

Important Note: Expedited Decisions

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN <24 HOURS/48 HOURS/72 HOURS>** **If you have a supporting statement from your doctor, please attach it to this request.**

If you or your doctor believe(s) that waiting **<15 days/30 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. We will automatically make a decision **within <24 hours/48 hours/72 hours>** if your doctor tells us that waiting **<15 days/30 days>** could seriously harm your health. Without your doctor's support for an expedited appeal, we will decide whether your case requires a faster decision. **Please note that you cannot ask for a faster appeal if you are asking us to pay you back for a drug you already received.**

Who is making this request? Provider ☐ **Member** ☐ **Appointed Representative** ☐
***Appointed Representatives*:** Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete the following section ONLY if the person making this request is not the Member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	Zip Code
Requestor Phone		

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Representation documentation for requests made by someone other than Member or the Member's prescriber:

Attach documentation showing the authority to represent the Member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan.

***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

<table>
<tr><td colspan="2">*Member Name:</td></tr>
<tr><td>*Member ID #:</td><td>*Date of Birth:</td></tr>
<tr><td>*Member Phone:</td><td>*Duration (how long therapy lasts):

Indefinite? ☐ **YES** ☐ **NO**
If the box above is left blank, it will be assumed that the request is indefinite.</td></tr>
<tr><td rowspan="2">*Drug Name/Strength/Form (i.e., tablet, capsule):</td><td>*Quantity:</td></tr>
<tr><td>*Frequency (i.e., how often, how many):</td></tr>
<tr><td colspan="2">*Generic Substitution Permitted: ☐ YES ☐ NO
If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.</td></tr>
<tr><td colspan="2">*Associated Diagnosis: list all diagnoses and ICD-10 codes being treated with the drug.</td></tr>
<tr><td>*Submitting Provider NPI:</td><td>*Provider Name (First Name & Last Name):</td></tr>
<tr><td colspan="2">*Provider Mailing Address (including city, state, ZIP):</td></tr>
<tr><td>*Provider Phone:</td><td>*Provider Fax:</td></tr>
<tr><td>*Office Contact Name:</td><td>*Provider Signature:</td></tr>
<tr><td>Pharmacy Name:</td><td>Pharmacy Phone:</td></tr>
<tr><td colspan="2">*Drug Allergies:</td></tr>
<tr><td colspan="2">DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)</td></tr>
<tr><td>Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried</td><td>RESULTS of previous drug trials. Indicate FAILURE vs INTOLERANCE (explain)</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
</table>

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What is the Member's current drug regimen for the condition(s) requiring the requested drug?	

Please explain your reasons for appealing. Use the space below and attach additional pages, if needed. Attach any information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in the Notice of Adverse Benefit Determination.

____

Signature of person requesting the appeal (the member, or the member's doctor or representative): ____

Date: ____________

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Notice of Non-Discrimination

WellCare of North Carolina complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation. WellCare of North Carolina does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

WellCare of North Carolina provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

WellCare of North Carolina provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Member Services at **1-866-799-5318** (TTY: **711**). If you believe that WellCare of North Carolina has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

DHHS ADA/RA Complaints
Office of Legal Affairs
2001 Mail Service Center
Raleigh, NC 27699-2001

You can file an ADA/RA (American with Disabilities Act/Rehabilitation Act) complaint by mail. You can ask for the form to file an ADA and/or RA complaint from the DHHS Compliance Attorney at **1-919-855-4800**. It is also available online at **https://files.nc.gov/ncdhhs/DHHS%20ADA%20Grievance%20Procedure%20June%202019.pdf**

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**
- **by mail** at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201; or

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- **by phone** at **1-800-368-1019** (TDD: **1-800-537-7697**)

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

If English is not your first language, we can help. Call **1-866-799-5318** (TTY: **711**). You can ask us for the information in this material in your language. We have access to interpreter services and can help answer your questions in your language.

Spanish: Si el inglés no es su lengua materna, podemos ayudarle. Llame al **1-866-799-5318** (TTY: **711**). Puede solicitarnos la información en este material en su idioma. Tenemos acceso a servicios de intérpretes que pueden ayudarle a responder preguntas en su idioma. Usted puede obtener este material y otra información del plan en letra de imprenta grande gratis. Para obtener materiales en letra de imprenta grande, llame a Servicios a Miembros al **1-866-799-5318**.

Chinese: 如果英語不是您的第一語言，我們可以提供幫助。請致電 **1-866-799-5318** (TTY: **711**)。您可以用 您的語言向我們詢問此材料中的訊息。我們可以使用口譯服務，並用您的語言幫助回答您的問題。您可以大字體免費獲得此材料以及其他計劃資訊。如需以大字體獲得材料，請致電會員服務 **1-866-799-5318** 。

Vietnamese: Nếu tiếng Anh không phải là ngôn ngữ mẹ đẻ của bạn, chúng tôi có thể giúp đỡ. Gọi theo số **1-866-799-5318** (TTY: **711**). Bạn có thể yêu cầu chúng tôi cung cấp thông tin trong tài liệu này bằng ngôn ngữ của bạn. Chúng tôi có quyền truy cập vào các dịch vụ thông dịch và có thể giúp trả lời câu hỏi của bạn bằng ngôn ngữ của bạn. Bạn có thể nhận tài liệu này và các thông tin khác về chương trình dưới dạng bản in khổ lớn miễn phí. Để nhận các tài liệu dưới dạng bản in khổ lớn, vui lòng gọi tới Ban Dịch Vụ Hội Viên theo số **1-866-799-5318**.

Korean: 영어가 모국어가 아닌 경우 도와드리겠습니다. **1-866-799-5318**(TTY : **711**)번으로 전화하십시오. 해당 자료에 포함된 정보들을 귀하의 언어로 받아보시려면 저희에게 요청해 주십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의 언어로 질문에 답변해 드릴 수 있습니다. 큰 활자로 인쇄된 본 자료 및 다른 플랜 정보를 무료로 받아보실 수 있습니다. 큰 활자로 인쇄된 자료를 이용하시려면 가입자 서비스에 **1-866-799-5318**번으로 전화 주십시오.

French: Si l'anglais n'est pas votre langue maternelle, nous pouvons vous aider. Composez le **1-866-799-5318** (TTY : **711**). Vous pouvez nous demander les informations contenues dans ce document dans votre langue. Nous avons accès à des services d'interprétation et pouvons vous aider à répondre à vos questions dans votre langue. Vous pouvez obtenir gratuitement ce matériel et d'autres informations sur le régime en gros caractères. Pour obtenir les matériaux en gros caractères, veuillez appeler les Services aux membres en composant le **1-866-799-5318**.

Arabic: إذا لم تكن الإنجليزية هي لغتك الأولى، فيمكننا تقديم المساعدة. اتصل بالرقم **1-866-799-5318** (TTY: **711**). يمكنك أن تطلب منا المعلومات الواردة في هذه المادة بلغتك. لدينا إمكانية الوصول إلى خدمات الترجمة الفورية ويمكننا المساعدة في الإجابة عن أسئلتك بلغتك. يمكنك الحصول مجانًا على هذه المواد وغيرها من معلومات الخطة مطبوعة بحروف كبيرة الحجم. للحصول على مواد مطبوعة بحروف كبيرة الحجم، اتصل بخدمات الأعضاء على الرقم **1-866-799-5318**.

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Hmong: Yog tias lus As Kiv tsis yog koj thawj hom lus, peb tuaj yeem pab koj tau. Hu rau **1-866-799-5318** (TTY: **711**). Koj tuaj yeem thov cov ntaub ntawv ua koj hom lus ntawm peb tau. Peb muaj kev pab cuam txhais lus thiab tuaj yeem pab teb cov lus nug ua koj hom lus tau. Koj tuaj yeem tau txais cov ntaub ntawv thiab lwm lub phiaj xwm li ntaub ntawv nyob rau tus qauv ntawv luam loj pub dawb. Los txais cov ntaub ntawv luam loj, hu rau Lub Chaw Pab Cuam Tswv Cuab ntawm **1-866-799-5318.**

Russian: Если английский не ваш родной язык, мы можем вам помочь. Звоните по номеру **1-866-799-5318** (TTY: **711**). Вы можете запросить у нас информацию об этом материале на вашем языке. У нас есть доступ к услугам переводчика, и мы можем вам помочь ответить на ваши вопросы на вашем языке. Вы можете бесплатно получить этот материал и другую информацию о плане крупным шрифтом. Чтобы получить материалы крупным шрифтом, позвоните в отдел обслуживания участников по телефону **1-866-799-5318**.

Tagalog: Kung ang Ingles ay hindi mo unang wika, makakatulong kami. Tumawag sa **1-866-799-5318** (TTY: **711**). Maaari mong hilingin sa amin ang impormasyon sa materyal na ito sa iyong wika. Mayroon kaming akseso sa mga serbisyo ng tagasalin at makakatulong upang masagot ang iyong mga katanungan sa iyong wika. Maaari mong makuha ang materyales na ito at iba pang impormasyon sa malalaking titik na anyo nang libre. Upang makuha ang mga materyales sa malalaking titik na anyo, tumawag sa Mga Serbisyo sa Miyembro sa **1-866-799-5318**.

Gujarati: જો અંગ્રેજી તમારી પહેલી ભાષા નથી, તો અમે મદદ કરી શકીએ. ક-લ **1-866-799-5318** (TTY: **711**). તમે અમને તમારી ભાષામાં આ સામગ્રીની માહિતી માટે પૂછી શકો છો. અમારી પાસે દુભાષિયા સેવાઓ માટે .ક્સેસ છે અને તમારી ભાષામાં તમારા પ્રશ્નોના જવાબમાં મદદ કરી શકીએ છીએ. તમે આ લખાણ અને અન્ય યોજના માહિતી મોટા અક્ષરોમાં વિનામૂલ્યે મેળવી શકો છો. મોટા અક્ષરોમાં લખાણ મેળવવા માટે, **1-866-799-5318** પર સભ્ય સેવાઓને કોલ કરો.

Khmer (Cambodian): ប្រសិនបើភាសាអង់គ្លេសមិនមែនជាភាសាទីមួយរបស់អ្នកទេយើង អាចជួយបាន។ ទូរស័ព្ទទៅលេខ **1-866-799-5318** (TTY: **711**)។ អ្នកអាចសួរយើងសម្រាប់ព័ត៌មាននៅក្នុងឯកសារនេះជាភាសារបស់អ្នក។ យើងអាចទទួលបានសេវាកម្មអ្នកបកប្រែភាសាហើយអាចជួយឆ្លើយសំណួររបស់អ្នកជាភាសារបស់អ្នក។ អ្នកអាចទទួលសំភារៈនេះ និងព័ត៌មានផ្សេងទៀតនៃគំរោង ជាអក្សរពុម្ពធំៗ ដោយឥតគិតថ្លៃ។ ដើម្បីទទួលសំភារៈ ជាអក្សរពុម្ពធំៗ ទូរស័ព្ទទៅផ្នែកសេវាសមាជិក តាមលេខ **1-866-799-5318**។

German: Wenn Englisch nicht Ihre Muttersprache ist, können wir Ihnen helfen. Rufen Sie **1-866-799-5318** (TTY: **711**) an. Sie können die Informationen in diesem Material in Ihrer Sprache anfordern. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen helfen, Ihre Fragen in Ihrer Sprache zu. Sie erhalten kostenlos dieses Material und andere Informationen über das Werk in Großdruck. Um die Informationen in Großdruck zu erhalten, rufen Sie Member Services unter der Nummer **1-866-799-5318** an.

Hindi: यदि अंग्रेजी आपकी पहली भाषा नहीं है, तो हम मदद कर सकते हैं। **1-866-799-5318** पर कॉल करें (TTY: **711**)। आप अपनी भाषा में इस सामग्री की जानकारी के लिए हमसे पूछ सकते हैं। हमारे पास दुभाषिया सेवाओं तक पहुंच है और आपकी भाषा में आपके सवालों के जवाब देने में मदद कर सकती है। आप इस विषय और अन्य योजना की जानकारी को बड़े अक्षरों में मुफ्त में प्राप्त कर सकते हैं। बड़े अक्षरों में विषय को प्राप्त करने के लिए, **1-866-799-5318** पर सदस्य सेवा को कॉल करें

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Laotian: ຖ້າພາສາອັງກິດບໍ່ແມ່ນພາສາທຳອິດຂອງທ່ານ, ພວກເຮົາສາມາດຊ່ວຍທ່ານໄດ້. ໂທຫາ **1-866-799-5318** (TTY: **711**). ທ່ານສາມາດຂໍເອົາຂໍ້ມູນໃນເອກະສານນີ້ເປັນພາສາຂອງທ່ານນຳພວກເຮົາໄດ້. ພວກເຮົາມີການເຂົ້າເຖິງການບໍລິການລ່າມແປພາສາ ແລະ ສາມາດຊ່ວຍຕອບຄຳຖາມຂອງທ່ານເປັນພາສາຂອງທ່ານໄດ້. ທ່ານສາມາດເອົາເອກະສານນີ້ ແລະ ຂໍ້ມູນແຜນການອື່ນທີ່ພິມເປັນແຜ່ນໃຫຍ່ໄດ້ຟຣີ. ເພື່ອເອົາເອກະສານນີ້ທີ່ພິມເປັນແຜ່ນໃຫຍ່, ໃຫ້ໂທຫາໜ່ວຍບໍລິການສະມາຊິກທີ່ເບີ **1-866-799-5318**.

Japanese: 英語が母国語でない場合もお手伝いいたします。**1-866-799-5318** (TTY: **711**)までお気軽にお電話ください。お使いの言語で本資料の情報をお問い合わせいただけます。通訳サービスを使用し、お使いの言語でご質問にお答えいたします。 本資料やその他の計画情報は大きな字体のものも無料で入手いただけます。大きな字体での資料をご希望の場合は、**1-866-799-5318**の会員サービスまでお電話ください。

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