

MEDICARE PART D REDETERMINATION REQUEST FORM

1. Member's Name: _____
2. Member ID Number: _____
3. Description of Part D drug in question: _____
4. Date the Part D drug was received: _____
5. I do not agree with the determination of my Part D authorization request/claim. MY REASONS ARE:

6. Date of the initial coverage determination notice _____
(If you received your initial determination notice more than [60 calendar days ago], include your reason for not making this request earlier.)

7. Additional information CarePlus Health Plans, Inc. should consider: _____

8. Requester's Name: _____
9. Requester's Relationship to the Member: _____
10. Requester's Address: _____

11. Requester's Telephone Number: _____
12. Requester's Signature: _____
13. Date Signed: _____
14. I have evidence to submit. (Attach such evidence to this form.)
 I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.



Instructions for submitting a Medicare Redetermination Request Form:

Send this form completed to CarePlus Health Plans, Inc. (CPHP) at 11430 NW 20th Street, Suite 300 Doral, FL 33172, Attn: Member Services Department or you may submit via fax to 1-800-956-4288. Note that CPHP may require additional information. See your plan benefits materials for more information. If you have any questions or need assistance in completing this form, please contact our Member Services Department at 1-800-794-5907. If you have a speech or hearing impairment and use a TTY device, please call 1-877-245-7930. We are open 7 days a week, from 8:00 a.m. to 8:00 p.m. However, from March 2, 2010 until the following Annual Election Period (AEP), you may leave us a voice mail message after hours, Saturday, Sundays and holidays and we will return your call the next business day.