

Medicare Prescription Drug Coverage and Your Rights

You have the right to request a coverage determination and get a written explanation from your Medicare drug plan if:

- Your prescriber or pharmacist tells you that your Medicare drug plan will not cover a prescription drug in the amount or form prescribed; or
- You are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription drug.

You also have the right to ask your Medicare drug plan for an exception (a special type of coverage determination) and get a written explanation from your Medicare drug plan if:

- You believe you need a drug that is not on your drug plan's list of covered drugs. The list of covered drugs is called a "formulary;"
- You believe a coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You believe you should get a drug you need at a lower cost-sharing amount.

What you need to do:

- Contact your Medicare drug plan to ask for a coverage determination, including an exception request.
- Refer to the benefits booklet you received from your Medicare drug plan or call 1-800-MEDICARE to find out how to contact your drug plan.
- When you contact your Medicare drug plan, be ready to tell them:
 - The prescription drug(s) that you believe you need. Include the dose and strength, if known.
 - The name of the pharmacy or prescriber who told you that the prescription drug(s) is not covered.
 - The date you were told that the prescription drug(s) is not covered.

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The Medicare drug plan's written explanation will give you the specific reasons why the prescription drug is not covered and will explain how to request an appeal if you disagree with the drug plan's decision.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0975. The time required to complete this information collection is estimated to average one minute per response, including the time to select the preprinted form, and hand it to the enrollee. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Acknowledgment of Receipt Form:

Patient signature (or legal guardian or parent): _____ Date: _____

Patient relationship: _____

Print name of signatory: _____