

CITRUS HEALTH CARE

Coverage Determinations, Appeals & Grievances

We encourage you to let us know right away if you have any questions, concerns, or problems related to your prescription drug coverage. Please call our Member Services at 1-877-624-8787 from 8AM to 8PM EST, Monday through Friday. TTY / TDD Users should call 1-888-248-7875.

This document gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

A complaint will be handled as a coverage determination, an appeal or a grievance, depending on the subject of the complaint.

Coverage Determinations

Your prescribing physician must provide, in response to a coverage determination request related to a non-formulary drug or tiering placement, written documentation of medical necessity for the requested medication.

There are two kinds of coverage determination requests—fast and standard. A member can request a fast coverage determination request, which will be reviewed within 24 hours. The request for a fast coverage determination request must meet criteria that the standard coverage determination review process time frame would jeopardize the member's health status. Fast decisions apply only to requests for Part D drugs that you have not received yet.

For standard coverage determination requests, notification will occur within 72 hours after receipt of the request or written documentation of medical necessity from the physician.

- Non-formulary drugs approved for coverage will be covered at the non-preferred brand level.
- Biotech and specialty non-formulary products approved for coverage will be covered at the specialty level.

A fast coverage determination request can be made by calling 1-800-546-5677, 24 hours a day, seven days a week. TTY users can call 1-866-706-4757. Be sure to ask for a "fast," "expedited," or "24-hour" review.

To obtain more information on the aggregate number of Citrus Health Care's grievances, appeals, and exceptions please contact Citrus Health Care customer service at 1-800-546-5677, 24 hours a day, seven days a week. TTY users can call 1-866-706-4757.

Please [click here](#) to access the Evidence of Coverage website page for more detailed information on coverage determinations.

Appeals (Redetermination)

An appeal is the type of complaint you or your appointed representative make when you or your appointed representative want us to reconsider and change a decision we have made about what prescription drug benefits are covered for you or what we will pay for a prescription drug. In order to file an appeal, you must first go through the coverage determination process. An appeal must be filed within 60 calendar days of the denied coverage determination. There are two types of appeals—fast and standard. Members can request a fast review of an appeal. The request for a fast appeal must meet the criteria that the standard process time frame would jeopardize the member's health status. These fast reviews will be completed within 72 hours. Standard appeal requests will be reviewed within seven calendar days. Members can make a fast appeal request by calling 1-800-546-5677, 24 hours a day, seven days a week. TTY users can call 1-866-706-4757. You can also fax your request to 1-866-632-7946. For a standard appeal, you can send a written appeal request to Medicare Part D Appeals, PO Box 407, Boys Town, NE 68010. You can also call 1-800- 546-5677, 24 hours a day, seven days a week. TTY users can call 1-866-706-4757. To make a standard appeal request or appoint a representative, see instructions and forms below:

- [Member Appeal \(Redetermination\) form](#)
- [Provider / Physician Appeal Form](#)
- [Appointment of Representative Form](#)

Second Level Appeal (Reconsideration)

If we deny any part of your appeal, you have the right to ask for an independent organization review of your case. This independent review organization contracts with the Federal government and is not part of our Plan. You must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal.

- There are two types of reconsiderations, fast and standard. The rules about asking for a fast reconsideration are the same as the rules about asking for a fast redetermination, except your prescribing doctor cannot file the request for you—only you or your appointed representative may file the reconsideration request. For a standard request, the independent review organization has up to seven calendar days from the date it gets your request to give you a decision. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice.

Please [click here](#) to access the Evidence of Coverage website page for more detailed information on the appeal process.

Grievances

A grievance is any complaint, other than one that involves a request for a coverage determination, or an appeal as described above because grievances do not involve problems related to approving or paying for Part D benefits. If you have a grievance, we encourage you to call customer service. We will try to resolve any complaint over the phone. You may also send your complaint in writing Medicare Part D Grievances, 5420 Bay Center Drive, Suite 250, Tampa, FL 33609.

You can also fax a grievance to: 813-490-8970.

We will notify you of a decision within 30 days of receipt of the written grievance. We may extend this time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. An expedited grievance can be made orally by calling 1-877-624-8787 (TTY/TTD users call 1-888- 248-7875) Monday - Friday, 8:00 a.m. - 8:00 p.m. Eastern.

If you would like to obtain an aggregate number of grievances, appeals and exceptions file, please contact Customer Service at 1-877-624-8787 (TTY/TTD users call 1-888-248-7875) Monday - Friday, 8:00 a.m. - 8:00 p.m. Eastern.

Please [click here](#) to access the Evidence of Coverage website page for more detailed information on all appeals and grievance policies.