Part D (Prescription Drug) Appeal Request Form

If you disagree with the decision for a request for coverage or payment for a prescription drug, you have the right to ask us for a reconsideration/redetermination (appeal) of our decision. You have 60 days from the date of our notice of denial to ask us for an appeal. You may also ask us for an appeal through our website.

Who May Make a Request: In addition to you**,** your physician/prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. To appoint another person to act as your representative, contact Customer Service and request an "Appointment of Representative" form.

Member Name:	ID#:	DOB:
Requestors Name (if other than member):		
Relationship to member:		
If representing the member, the first 3 lines of information should be your information.		
Address:		
City:	State:	Zip:
Telephone #:		
What you are appealing:		
Reference/Claim #:		
Date of Service (if applicable):	Date of Decision Notice:	
Prescriber Name:	Office phone:	
Name of drug:	Strength/quantity/dose:	
Have you purchased the drug pending appeal? ☐ Yes ☐ No		
If "yes" - Date Purchased:	Amount paid: (attach copy of receipt)	
Name and telephone number of pharmacy:		
Please indicate the reason for the appeal: *(Use the back of this form if you require more space)*		

Is there additional information we should consider when reviewing this appeal?		
Important Note: Expedited Decisions Medicare Prescription Drug - If you believe that waiting 7 days for a standard prescription drug decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. ☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. Expedited appeal requests can also be made by phone at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 5 p.m. local time.		
Signature:	Date:	Time:

Please mail or fax completed form to:

ATRIO Health Plans
Appeals and Grievances
PO Box 5600
Scranton, PA 18505

Fax: 1-866-339-8751

For assistance with this form or questions regarding your appeal, please contact our Customer Service department at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.