MetroPlus Advantage (HMO D-SNP)
PO Box 52066
Phoenix, AZ 85072-2066

FirstName LastName
Address1
Address2
City, State ZipCode

MetroPlusHealth
50 Water Street
7th Floor
New York , NY 10004
1-866-693-4615

NOTICE OF DISMISSAL

09/14/2021

FirstName LastName
Address1
Address2
City, State ZipCode

Dear FirstName LastName:

MetroPlus Advantage (HMO D-SNP) is your Medicare prescription drug plan provider. We are writing to let you know that we have dismissed your request for coverage of the following prescription drug:

PREDNISONE TAB 10MG; COMBIGAN SOL 0.2/0.5%

The request was dismissed due to the following reason:

- We were unable to approve your request for reimbursement because our records indicate that the prescription drug(s) submitted with the request were previously processed through your Plan benefit, and that appropriate copays and deductibles have been applied. Your claim paid appropriately at time of processing, therefore no additional reimbursement will be provided. If you have secondary insurance, please submit your reimbursement request to your secondary insurance provider. If you would like us to reconsider our decision, you may file an Appeal. More information about submitting an appeal may be found below. If you have questions or need assistance, please call the toll-free number on your Prescription Benefit ID card.

Should you have questions about this letter, or need assistance to name an appointed representative, please call us toll free. Our number is 1-866-693-4615, 24 hours a day, 7 days a week. TTY users should call 711.

Thank you for allowing MetroPlusHealth to help you get the most from your Medicare prescription drug plan.

Thank you,

MetroPlusHealth

MetroPlus is an HMO health plan with a Medicare contract. Enrollment in MetroPlus depends on contract renewal.

If you have any questions, or if you would like to request a copy of your case file, please call 1-866-693-4615, 24 hours a day, 7 days a week. TTY users may call 711.

This information is available for free in other languages. We can also give you information in Braille, in large print, or other alternate formats if you need it. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-986-0356 (TTY: 711). ATENCIÓN: si habla español, cuenta con servicios de asistencia lingüística sin cargo disponibles para usted. Llame al 1-866-986-0356 (TTY: 711).

What If I Don't Agree With This Decision?

You have the right to appeal. If you want to appeal this dismissal action, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?

You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at: 1-866-693-4615 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY: 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- ☐ **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- ☐ If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal. If you're appealing a dismissal of request for payment of a drug you've already received, we'll give you a written decision within 14 days.

What Do I Include with My Appeal Request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach. You should include any information you believe could change the decision to dismiss your coverage request. If we requested information that you or your doctor has not yet submitted, you should include it in your appeal.

How Do I Request an Appeal?

You, your prescriber, or your representative should submit your appeal to one of the following:

Phone: 1-866-693-4615

TTY: 711

Fax: 1-855-230-5549

Plan Website: www.metroplusmedicare.org

Address: CVS Caremark
P.O. Box 52066,
Phoenix, AZ, 85072-2066

Of note, your plan must accept expedited (fast) appeals made over the phone but is not required to accept standard appeals made over the phone.

What Happens Next?
If you appeal, we will review your case and give you a decision. Our decision will be limited to whether to reverse (cancel) the dismissal. If we reverse the dismissal, we will review your coverage request and decide whether the requested drug will be covered for you.

Get help & more information

- MetroPlus Advantage (HMO D-SNP) Toll Free: 1-866-693-4615
  TTY users call: 711
  24 hours a day, 7 days a week
  www.metroplusmedicare.org
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050 (1-888-466-9050)
- Elder Care Locator: 1-800-677-1116
- State Health Insurance Program National Technical Assistance Center: 877-839-2675