

Prescription drug you are requesting:

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: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions

If you or your prescriber believes that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS

If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Signature of person requesting the appeal (the enrollee or the representative):

_____ **Date:** _____

Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715-631-7411 (voice)** or toll free at **1-855-931-4850 (voice)**, **715-631-7413 (TTY)**, or **1-855-931-4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715-631-7411** or toll free at **1-855-931-4850 (voice)**; **715-631-7413** or toll free at **1-855-931-4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance

Mailing Address

Attn: Appeals and Grievances

Aspirus Health Plan

P.O. Box 51

Minneapolis, MN 55440

Email: cagMA@aspirushealthplan.com

Fax: 715-631-7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715-631-7411/1-855-931-4850 (телетайп: 715-631-7413/1-855-931-4852).

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተሎ ቁጥር ይደውሉ 715-631-7411/1-855-931-4850 (መስማት ስተሳናቸው: 715-631-7413/1-855-931-4852)።

ဝတ်သည့်ဝတ်သေး-နမူကတိက ကညီ ကျိုက်အယ်, နမူနာ ကျိုက်အတ်မာစာလော တလက်ဘူလ်စု နီတံဘော်သုန့်လီ. ဝိ: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាអង់គ្លេស, រសវាជំនួយវេជ្ជកម្មភាសា ដោយមិនគិតថ្លៃលក្ខណៈគឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (715-631-7411/1-855-931-4850 (رقم هاتف الصم والبكم: 715-631-7413/1-855-931-4852).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715-631-7411/1-855-931-4850 (ATS : 715-631-7413/1-855-931-4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715-631-7411/1-855-931-4850 (TTY: 715-631-7413/1-855-931-4852).