Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

1 Request for Medicare Prescription Drug Coverage Determination

This form may be sent to us by mail or fax:

Address:
BCN Advantage
Clinical Pharmacy Help Desk – MC TC1308
P.O. Box 807
Southfield, MI 48037

Fax number:
1-866-601-4428

Requests for coverage determination can also be made by phone at 1-800-437-3803 or at https://www.bcbsm.com/medicare/help/forms-documents/pharmacy-drug-coverage/determination.html.

Who can make a request: You may request a coverage determination. Also, your prescriber can ask us for a coverage determination on your behalf. A family member, friend, or someone else you trust can also make a request for you if they are your designated representative. Contact us to learn how to name a representative.

☐ Mr. ☐ Mrs. ☐ Ms.	Enrollee First name	Middle initial	Last name
Birth date / /	Sex ☐ Male ☐ Female	Daytime phone number ( )	Alternate phone number ( )
Permanent residence street address (*No P. O. box*)		City	State
ZIP code	County	Enrollee's member ID#	

2 Complete the following section ONLY if the person making this request isn't the enrollee or prescriber

☐ Mr. ☐ Mrs. ☐ Ms.	Requestor First name	Middle initial	Last name
Requestor's relationship to enrollee			
Requestor permanent residence street address (*No P. O. box*)		City	State
ZIP code	County	Requestor telephone number	

BCN Advantage℠ is an HMO-POS and HMO plan with a Medicare contract.
Enrollment in BCN Advantage depends on contract renewal.

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3 Type of coverage determination request

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent).

For more information on appointing a representative, contact your plan or 1-800-MEDICARE.

Name of prescription drug you're requesting (if known, include strength and quantity requested per month):

☐ I need a drug that isn't on the plan's list of covered drugs.

☐ I've been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year.

☐ I request prior authorization for my prescription.

☐ I request an exception to the requirement that I try another drug before I get the drug prescribed.

☐ I request an exception to the plan's quantity limit on the number of pills I can receive so that I can get the number of pills prescribed.

☐ My drug plan charges a higher copayment for the drug prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment.

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier.

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

NOTE: If you're asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement) may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization".

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4 Additional information we should consider (attach any supporting documents):

5 Important Note: Expedited decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we'll automatically give you a decision within 24 hours. If you don't obtain your prescriber's support for an expedited request, we'll decide if your case requires a fast decision. You can't request an expedited coverage determination if you're asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITIN 24 HOURS** (If you have a supporting statement from your prescriber, attach it to this request).

Signature of person requesting the coverage determination (the enrollee, or the enrollee's prescriber or representative):

Signature	Date / /