

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD



**COVERAGE DETERMINATION REQUEST
COMPLETED BY MEMBER**

The following drugs are not covered: fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Member's Information		
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Name	Date of Birth	HealthChoice ID Number
Member's Address	City	State Zip Code
()		
Phone		
Representative's Information		
Representative's Name (if not enrollee)		
Representative's relationship to member (if other than prescribing physician, attach documentation showing the authority to represent the member)		
Prescription Information		
Drug Name	Strength	Quantity and Quantity Requested Per Month
Prescribing Physician's Information		
Name		Medical Specialty
Address	City	State Zip Code
()	()	
Office Phone	Fax	Contact Person

What Type of Coverage Determination Do You Want to Request?

- I need a drug that is not on the HealthChoice Medicare Formulary. I want to request a formulary exception.
- A drug I am taking is being removed from the HealthChoice Medicare Formulary. I am requesting a formulary exception to receive continued coverage for the drug.
- I am requesting a formulary exception to the requirement that I try another drug before HealthChoice will pay for the drug my doctor prescribed.
- I am requesting a prior authorization for a drug my doctor has prescribed.
- I disagree with the plan's limit on the number of pills I can receive (quantity limitation). I am requesting a formulary exception to receive the number of pills prescribed by my doctor.
- HealthChoice charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition. I am requesting a tier exception to receive my medication at the lower copayment.
- A drug I am taking is moving to a higher copayment tier. I am requesting a tier exception to continue to receive my drug at the lower copayment.
- I paid for a covered drug out of my own pocket. I am requesting a coverage determination about payment so that I can get reimbursed by HealthChoice.

***NOTE: If you are asking for a formulary or tier exception, your PRESCRIBING PHYSYCIAN must provide a statement to support your request.**

Additional Information we should consider (attach any supporting documents)

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision by marking the box below. If your prescribing physician asks for a fast decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

- I need an expedited coverage determination (attach physician's supporting statement, if applicable)

Member/Representative's Signature

Date

Return this request to Medco Health, Attention: Coverage Appeals 8111 Royal Ridge Parkway, Irving, TX 75063. Be aware that additional information may be requested. For additional information about requesting a coverage determination, see your HealthChoice Medicare Supplement Part D Plan handbook or log on to www.healthchoiceok.com.