Medicare Appeals and Grievances

What is an Appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare or your Medicare plan. You have the right to appeal any decision about your Medicare services. You can appeal if Medicare or your plan denies:

- A request for a health care service, supply, or prescription that you think you should be able to get
- A request for payment for health care services or supplies or a prescription drug you already got that was denied
- A request to change the amount you must pay for a prescription drug

You can also appeal if Medicare or your plan stops **providing or paying for all or part of** an item or service you think you still need.
If you decide to file an appeal, ask your doctor or other health care provider or supplier for any information that may help your case.

How do I file an Appeal?

How you file an appeal depends on the type of Medicare coverage you have.

If you have Original Medicare:
If you want to file an appeal, get the **Medicare Summary Notice (MSN)** that shows the item or service you're appealing. You must file the appeal within 120 days of the date you get the MSN.

You can file your appeal in one of two ways:
1. Follow the instructions on the back of the MSN.
2. Fill out the **Redetermination Request Form**, and send it to the Medicare contractor at the address listed on the MSN.

You will generally get a decision from the Medicare contractor (either in a letter or a Medicare Summary Notice) within 60 days after they get your request.

If you have a Medicare health plan, learn how to file an appeal by looking at the materials your plan sends you each year, calling your plan, or reading about **How to File a Complaint (Grievance or Appeal)** and **Your Medicare Rights and Protections**.

If you have a Medicare Prescription Drug Plan, you have the right to do all of the following (even before you buy a certain drug):

- Get a written explanation (called a "coverage determination") from your Medicare drug plan. A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your benefits, including whether a certain drug is covered, whether you've met the requirements to get a requested drug, how much you pay for a drug, and whether to make an exception to a plan rule when you request it.
- Ask for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your plan's formulary.

Related Links

1-800 Billing Questions Fact Sheet

Your Medicare Rights and Protections

- Ask for an exception if you or your prescriber believes that a coverage rule (such as prior authorization) should be waived.
- Ask for an exception if you think you should pay less for a higher tier (more expensive) drug because you or your prescriber believes you can't take any of the lower tier (less expensive) drugs for the same condition.

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription, the pharmacist will show you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't show you this notice, ask to see it.

You or your prescriber may make a standard request by phone or in writing, if you're asking for prescription drug benefits you haven't received yet. If you're asking to get paid back for prescription drugs you already bought, you or your prescriber must make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't received the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why the exception should be approved.

What if I think My Services are Ending Too Soon?

If you're getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon, you have the right to a fast appeal. Your provider will give you a written notice before your services end that tells you how to ask for a fast appeal. If you're not given this notice, ask for it!

Can Someone Help Me File an Appeal?

Contact your **State Health Insurance Assistance Program (SHIP)** if you need help filing an appeal.

If you want Medicare to give your personal health information to someone other than you, you need to let Medicare know in writing by filling out the **Authorization to Disclose Personal Health Information** form.

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