Humana.

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:
Humana Clinical Pharmacy Review (HCPR)
P.O. Box 33008
Louisville, KY 40232-3008

Fax number:
1-877-486-2621

You may also ask us for a coverage determination by phone at 1-800-555-2546 or through our website at www.humana.com/determination.

Who may make a request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's information

Enrollee's name		Date of birth
Enrollee's address		
City	State	ZIP code
Phone	Enrollee's member ID number	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's name		
Requestor's relationship to enrollee		
Address		
City	State	ZIP code
Phone		

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 (1-800-633-4227).