Know Your Medicare Rights

By Cate Kortzeborn

As a person with Medicare, you have important rights. One of them is the right to appeal.

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare health plan. For example, you can appeal if Medicare or your plan denies:

- A request for a health care service, supply, item, or prescription drug that you think you should get.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to reduce the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal if Medicare or your Medicare Advantage plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. Keep a copy of everything you send to Medicare or your health plan as part of your appeal!

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

1. Get the "Medicare Summary Notice" (MSN) that shows the item or service you're appealing. Your MSN is the notice you get every 3 months that lists all the services billed to Medicare, and tells you if Medicare paid for the services.
2. Circle the item(s) you disagree with on the MSN, and write an explanation of why you disagree with the decision on the MSN or a separate piece of paper and attach it to the MSN.
3. Include your name, phone number, and Medicare number on the MSN, and sign it. Keep a copy for your records.
4. Send the MSN, or a copy, to the company that handles bills for Medicare (known as the Medicare Administrative Contractor) listed on the MSN. You can include any additional information about your appeal. Or you can use CMS Form 20027 and file it with the company that handles bills for Medicare. To view or print this form, visitwww.cms.gov/cmsforms/downloads/cms20027.pdf. Or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users should call 1-877-486-2048.

You must file the appeal within 120 days of the date you get the MSN in the mail. You'll generally get a decision from the Medicare Administrative Contractor within 60 days after they receive your request. If Medicare will cover the item(s) or service(s), they'll be listed on your next MSN.

If you have a Medicare Advantage or other health plan, read the materials your plan sends you, call your plan, or visitwww.Medicare.gov/appeals. In some cases, you can file an expedited, or fast appeal.

If you have a Medicare prescription drug plan, even before you pay for a given drug, you have the right to:
- Get a written explanation (called a "coverage determination") from your Medicare drug plan. A coverage determination is the initial 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's legally allowed to write prescriptions) believe you need a drug that isn't on your plan's formulary.
- Ask for an exception if you or your prescriber believe that a coverage rule (like 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 believe you can't take any of the lower tier (less expensive) drugs for the same condition.