



2240 EastRidge Center  
Eau Claire, WI 54701  
Voice/TTY: (715) 838-2900  
Toll Free: (800) 842-1814

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## INSTRUCTIONS FOR COMPLETING THE MEMBER REQUEST FOR MEDICARE PART D COVERAGE DETERMINATION FORM

### **Purpose of the Form**

This form is intended for Partnership member use to provide guidance in requesting coverage determinations – including exceptions requests from Community Health Partnership.\*

### **PLEASE NOTE:**

The member, the member's appointed representative, or the member's prescribing physician can submit a request for a Medicare Part D coverage determination.

This form must be forwarded to Community Health Partnership. Please be sure that the form is signed and dated.

Oral supporting statements can be made by calling **1-800-546-5677 24 hours a day, seven days a week (TTY Users should call 1-866-706-4757)**.

Upon completion, the form can be sent by facsimile to **1-866-632-7946**. Or **mailed to:**

Part D Coverage Determinations  
PO Box 407  
Boys Town, NE 68104

*\*Our standard response time for Medicare Part D prescription drug coverage requests is 72 hours. If your request is urgent, it is important that you call and ask for the request to be expedited.*