MEDICARE DMEPOS SUPPLIER STANDARDS
MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

MEDICARE DMEPOS SUPPLIER STANDARDS

Introduction

The products and/or services provided to you by Vital Care are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation).

The full text of these standards can be obtained at http://ecfr.gpoaccess.gov

Protocol for Resolving Complaints from Medicare Beneficiaries

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the “Medicare Beneficiaries Complaint Log” and completed forms will include the patient’s name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient are informed of this complaint resolution protocol at the time of set up of service.

MEDICARE PRESCRIPTION DRUG COVERAGE AND YOUR RIGHTS

Your Medicare Rights

You have the right to request a coverage determination from your Medicare drug plan if you disagree with information provided by the pharmacy. You also have the right to request a special type of coverage determination called an “exception” if you believe:

- You need a drug that is not on your drug plan’s list of covered drugs. The list of covered drugs is called a “formulary;”
- A coverage rule (such as prior authorization or a quantity limit) should not apply to you for medical reasons; or
- You need to take a non-preferred drug and you want the plan to cover the drug at the preferred drug price.

What You Need To Do

You or your prescriber can contact your Medicare drug plan to ask for a coverage determination by calling the plan’s toll-free phone number on the back of your plan membership card, or by going to your plan’s website. You

or your prescriber can request an expedited (24 hour) decision if your health could be seriously harmed by waiting up to 72 hours for a decision. Be ready to tell your Medicare drug plan:

1. The name of the prescription drug that was not filled. Include the dose and strength, if known.
2. The name of the pharmacy that attempted to fill your prescription.
3. The date you attempted to fill your prescription.
4. If you ask for an exception, your prescriber will need to provide your drug plan with a statement explaining why you need the off-formulary or non-preferred drug or why a coverage rule should not apply to you.

Your Medicare drug plan will provide you a written decision. If coverage is not approved, the plan's notice will explain why coverage was denied and how to request an appeal if you disagree with the drug plan's decision.

Refer to your plan materials or call 1-800-Mediare for more information.

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CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

See reverse side of form for additional important information.