PRIOR AUTHORIZATION APPEAL REQUEST

An appeal may be filed in the event that you wish for us to reconsider and change a decision we have made about what prescription drug benefits are covered for the member. The appeals process must be initiated within 180 days of the original denial. Standard appeal requests will be reviewed within 7 working days. You may request an expedited appeal if the member's health status is jeopardized by the standard processing time in which the appeal will be processed. Expedited appeal requests will be reviewed within 72 hours. To make an appeal, please complete the form below and fax it to 844-508-4690 along with any additional supporting evidence. For questions regarding appeals, please contact provider services at 855-865-4688.

APPEAL REQUEST

Please indicate the request you are submitting:

☐ **STANDARD** – decision will be made within 7 working days

☐ **EXPEDITED** – decision will be made within 72 hours

Date of Submission: _____

PROVIDER INFORMATION		**PATIENT INFORMATION**	
PROVIDER NAME	PROVIDER ID	PATIENT NAME	
PHYSICIAN ADDRESS (street, city, state, zip)			
PHONE	FAX	PATIENT'S DOB	DIAGNOSIS

If additional space is needed, please use separate sheet and attach to form.

Prior Authorization Decision in Question:

I do not agree with the determination of the Prior Authorization request. MY REASONS ARE:

Additional information for us to consider:

I certify that the information above is accurate. I understand that penalties may apply for falsified or misrepresented information.

Requester's Signature:_____ Date:_____
Requester's Name:_____ Relationship to member:_____
Requester's Address_____ Requester's phone:_____

Please Return Completed Form To:
Fax Number: 844-508-4690