Nevada Medication Assistance Program

CLAIMS AUTHORIZATION REQUEST FORM

Version 1

Provider Services: 888-311-7632
Fax Form to: 800-848-4241
or 510-587-2799

*PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS! **To be completed by the Pharmacy***

PHARMACY INFORMATION

NPI: _____

CONTACT PERSON: _____
STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) _____

FAX: ( ) _____

MEMBER INFORMATION
(Print Clearly)

_____
Last Name First Name

I.D.: _____

D.O. B. _____ / _____ / _____

MUST CHECK ALL THAT APPLY
PROOF OF BILLING MUST ACCOMPANY THIS REQUEST

Program Limits

☐ Claim over 90 days

Plan Limits

☐ ARV Daily QTY Max
***Submit rational of exceeding the recommended daily dose in the exception explanation section below.*

☐ Day supply less than minimum required

☐ Lost med fill

☐ Stolen fills
** Police report MUST be attached for stolen fills.*

☐ Vacation Supply

All Claims over 90 days will be denied.

			Copay	Requested QTY	Days Supply	OCC	Date of Fill
RX#1 _____	NDC : _____-_____-_____	$:	_____		_____		_____
RX#2 _____	NDC : _____-_____-_____	$:	_____		_____		_____
RX#3 _____	NDC : _____-_____-_____	$:	_____		_____		_____
RX#4 _____	NDC : _____-_____-_____	$:	_____		_____		_____
RX#5 _____	NDC : _____-_____-_____	$:	_____		_____		_____
RX#6 _____	NDC : _____-_____-_____	$:	_____		_____		_____

Notes/Explanation:

****Confidential****