

Delaware ADAP **Ramsell* CLAIMS AUTHORIZATION REQUEST FORM

Provider Services: 888-311-7632 Fax Form to: 800-848-4241

or 510-587-2799

Version 8.1

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

PHARMACY INFORMATION NPI: CONTACT PERSON:	CLIENT INFORMATION (Print Clearly)	MUST CHECK ALL THAT APPLY! PROOF OF BILLING MUST ACCOMPANY THIS REQUEST
PHONE: () FAX: ()	Last Name First Name I.D.:	Plan Limit □ CII or CIII Max* *original Rx required □ Maximum fills per year □ ARV Daily QTY Max**Submit w/Treatment Exception Request (TER) form □ Day supply with copay □ Day supply less than minimum
RX#1 NDC : RX#2 NDC : RX#3 NDC : RX#4 NDC : RX#5 NDC : RX#6 NDC :	\$:	Clinical Limits □ Code 1 or Diagnosis Required □ Supplemental Form Required Other □ DAW □ Insurance/Plan Denial** Must provide detailed denial information from the primacy insurance.
Notes/Explanation:		