ILLINOIS MEDICATION ASSISTANCE PROGRAM - ADAP
CLAIMS AUTHORIZATION REQUEST FORM
Version 1

Provider Services: 888-311-7685
Fax Form to: 800-848-4241
or 510-587-2799

PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS.

PHARMACY INFORMATION

NPI: _____

CONTACT PERSON: _____

STAMP OR WRITE: Pharmacy Name, Phone & Fax

PHONE: ( ) _____

FAX: ( ) _____

CLIENT 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
☐ Greater than 13 fills / Year
☐ Claim over _____ days
☐ Days supply greater than maximum
☐ Lost Med fill
☐ Vacation Supply
☐ Lost Vacation Supply
☐ Generic Dispensing Exception

Plan Limits
☐ ARV Daily QTY Max**
  **Submit rational of exceeding the recommended daily dose in the exception explanation section below.*
☐ ARV Duplicate Therapy**
  **Submit rational of duplicate therapy in the exception explanation section below.*
☐ ARV Drugs/Components not Recommended**
Submit rational of therapy not recommended in the exception explanation section below.

NOTES

All Claims over 180 days will be denied.

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

Exception Explanation: