CLAIMS AUTHORIZATION REQUEST FORM

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. _____ / _____ / _____

Prescription Details

	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: _____ - _____ - ___	$_____		_____		_____

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

Program Limits
- ☐ Program/Plan Max Exceeded $ _____
- ☐ Prescription Cost Exceeds Max $_____
- ☐ Refill Too Soon
- ☐ Claim Too Old

Plan Limits
- ☐ Fills Per Year Exceeded
- ☐ Fills Per Prescription _____
- ☐ Max Day Supply At Retail Exceeded _____
- ☐ Early Refill Due To *(Circle applicable exception and indicate approval dates):*
  Lost / Vacation / Stolen
  Approval Dates _____
- ☐ DUR-Duplicate RxScreening **

Formulary and Billing Exceptions **
- ☐ Brand Dispensing Exception
- ☐ PSC/DAW Exception ____
- ☐ Other Coverage Code (OCC) Exception ____
- ☐ Compounds

*** Submit rationale for authorization of dispensing not allowed in the Exception Explanation section below.*

Exception Explanation:

All Claims over 90 days will be denied.