

Texas SPAP/TIAP/ACA 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
STAMP or WRITE Pharmacy Name, Phone & Fax: PHONE: ()	Last Name First Name I.D.:	Program Limits ☐ Max \$ per prescription override ☐ Claim over days Plan Limit ☐ Day supply with copay
FAX: ()	D.O. B//	Clinical Limits □ Code 1 or Diagnosis Required
All Claims over 180 days will be denied.	Copay or Requested Days Prescription Cash Price QTY Supply OCC Date*	☐ Step Therapy Override ☐ Supplemental Form Required Other ☐ DAW
RX#1 NDC :	\$:	☐ Insurance/Plan Denial** Must provide
RX#2 NDC :	\$:	detailed denial information from the primacy insurance.
RX#3 NDC :	\$:	primacy insurance.
RX#4 NDC :	\$:	
RX#5 NDC :	\$:	
RX#6 NDC :	\$:	
RX#7 NDC :	\$:	
RX#8 NDC :	\$:	
Notes/Explanation:		