Medicaid Medication Appeal Request

Fax request to 1-888-865-6531 along with all pertinent medical records.
Contact Customer Service with any questions.
Complete each section legibly.

The appeal request is being initiated by: (please select only one option)

☐ Physician (or office staff member acting on behalf of physician) ☐ Member ☐ Appointed Representative

Member's name:	Date of request:	**Name of person requesting this appeal and their relationship to the member:**
Member ID number:		**Original coverage determination date:** **Ticket number:**
Date of birth:		Requestor's phone number:
Member's phone number:		Requestor's address: *(if applicable)*
Member's address:		
Diagnosis:		Requestor's fax number: *(if applicable)*
Medication name:		Physician's name:
Medication strength and dose:		Contact person at physician's office:
Quantity and day supply:		Physician phone:
Length of treatment being requested:		Physician fax:
Clinical reason for appeal: (include medical documentation)		
History/Allergies:		

☐ **REQUEST FOR EXPEDITED REVEW (72 HOURS)**
BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN'S AGENT CERTIFIES THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.