Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

PHARMACY APPEAL/ RECONSIDERATION

PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____Beneficiary's Medicaid: _____

DOB: _____ City:_____
Month/ Day/ 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI #:_____

Medicaid ID #: _____ Phone #: _____FAX:_____

City:_____ State: _____

_____
Physician's signature and date

I hereby certify that I am the ordering physician/ nurse practitioner/ physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____Provider #: _____

Drug Name: _____ Strength:_____

Reference PA #:_____

City:_____ State: _____ Phone #: _____FAX:_____

REQUEST INFORMATION

Date of Request: _____ Requested By: Physician ☐ Beneficiary ☐

Date of Denial Notification: _____
*Requester is encouraged to submit any additional information to support the request for appeal

RATIONALE/ MEDICAL REASON FOR DISAGREEMENT