**PHARMACY RECONSIDERATION REQUEST FORM**

CHANGE HEALTHCARE MS PRIOR AUTHORIZATION DIVISION
45 Commerce Drive, Suite 5
PO Box 1090
Augusta, ME 04332
Fax to: **1-877-537-0720** Ph: 1-877-537-0722
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

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**BENEFICIARY INFORMATION**

| Beneficiary ID: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ | DOB: ___ ___ / ___ ___ / ___ ___ ___ |
|---------------------------------------------------------|

Beneficiary Full Name: __________________________________________________________________________

**PRESCRIBER INFORMATION**

<table>
<thead>
<tr>
<th>Prescriber’s NPI:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber’s Full Name:</td>
<td></td>
</tr>
<tr>
<td>Prescriber’s Address:</td>
<td>FAX:</td>
</tr>
</tbody>
</table>

**RECONSIDERATION REQUEST**

- MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.
- If you have submitted a prior authorization that has been denied, you may submit a reconsideration form.
- A beneficiary or a prescriber may request a reconsideration by completing this form.
- Beneficiary and/or prescriber is encouraged to submit any additional information that could result in an override of the determination.

**PA REQUEST INFORMATION:**

Date of Request: __________ Requested By: ☐ Prescriber ☐ Beneficiary

Drug Name: ____________________________________________ Drug Strength:_________________________ Quantity:_________________________

Date of Denial Notification: __________ Tracking # (found on denial letter) if available ______________________________

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**RATIONALE/MEDICAL REASON FOR RECONSIDERATION**

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SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

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05/24/2017