

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/>



BENEFICIARY INFORMATION

Beneficiary ID: _____ - _____ - _____ DOB: ____/____/____

Beneficiary Full Name: _____

PRESCRIBER INFORMATION

Prescriber's NPI: _____

Prescriber's Full Name: _____ Phone: _____

Prescriber's Address: _____ FAX: _____

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 _____

RATIONALE/MEDICAL REASON FOR RECONSIDERATION

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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