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

05/24/2017