

# 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**

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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