prescryptive™

REWRITING THE SCRIPT

Appeals Form

Use this form to appeal pharmacy claim decisions.

What are you appealing?
Type of Request (if known). Please select the one that most applies.

- ☐ Level I Appeal
- ☐ Level II Appeal
- ☐ Level III - External Review Appeal

Submit this form to:
Prescryptive Health
Pharmacy Prior Authorizations
PO Box 403
Redmond, WA 98073
Or by Fax: (877) 843-9375

Member Information

First Name:		Last Name:		Date of Birth: (MM/DD/YY)		Phone:	
ID Prefix:		ID Number:		Suffix:		Group Policy #:	
Address:		City:		State:	Choose State	Zip:	

Appeal Authorization: Who can appeal on your behalf?

This section must be completed by the member.

First Name:		Last Name:		Phone:			
Relationship to Member:				Fax:			
Address:		City:		State:	Choose State	Zip:	

Provider Information

Provider of Care: (e.g.: Doctor's name, hospital, laboratory)							
Address:		City:		State:	Choose State	Zip:	
NPI:				Tax ID:			
Provider Contact Name:				Phone:		Fax:	

Claim Information

Date of Service (MM/DD/YY):		Claim Number:		Total Charge:	
Utlization Management Reference # (listed on denial letter):					
Medication:					

For questions about this form or to inquire about a request under review, please call: (206) 686-9016

Why are you appealing?

What would you like us to review again?
Write in the space below (attach supporting documents)

What action do you want us to take?
Write in the space below (if you need more space, you may attach a written statement)

RELEASE OF HEALTHCARE INFORMATION AND RECORDS

By signing this form I understand and agree to the following: Prescryptive Health, or any of its affiliates (the "Company"), may disclose my health records with the Authorized Representative listed above.

I understand that the healthcare information may include my benefit, claim, diagnosis and treatment records including information about the following sensitive healthcare diagnosis and treatment unless I cross one or more from the list:

- Alcohol and/or Chemical dependency
- Sexually Transmitted Diseases (HIV/AIDS)
- Genetic information
- Reproductive health (including abortion)
- Psychiatric disorders/Mental Illness

You can change your mind and withdraw this release at any time by informing the Company in writing at the address listed at the bottom of this form. The Company will make sure the change goes into effect within five business days after receiving your withdraw request and will not be liable for any information released before your change goes into effect. This release is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this release. The release will last twenty-four months from the signature date below, or until the appeal process is complete, whichever is earlier.

Member/Requester Signature: _____ Date: _____

Is this request urgent? Yes ☐ No ☐ "Urgent" is defined as when you (the provider) believe that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. You must explicitly state in the documentation why you believe the request warrants an urgent decision.

APPEALS FORM SUBMISSION

Fax this completed form to our secure fax machine at: (877) 843-9375
Or mail to: Prescryptive Health, Pharmacy Prior Authorizations
PO Box 403
Redmond, WA 98073