Prescription Drug Coverage Appeal Form

Patient Information

Full Name

Date of Birth

Member ID/Policy Number

Phone Number

Prescriber Information

Prescriber Name

Phone Number

Fax Number

NPI

Drug Information

Drug Name

Dosage/Strength

Quantity

Directions for Use

Reason for Appeal

Supporting Information

Medical Justification

Previous Medications Tried

Contact Information for Notification

Contact Name

Contact Phone

Contact Email