

**MEDICATION APPEAL REQUEST**

**INSTRUCTIONS:**

• Complete the form below. **Fields with an asterisk (\*) are required.**

* **Include:**

**Optum Rx denial letter\***

**Letter of appeal explaining why medication is necessary\***

**Supporting clinical documentation\***

**Mail or Fax completed form and attachments to:**

Prime Healthcare

Attn: EHP/RX Appeal

**Fax:** 833-679-4289

**Mail:** 3480 E. Guasti Rd.

Ontario, CA 91761

For assistance, please contact Prime Healthcare Customer Service: 877-234-5227

**Provider Information**

|  |
| --- |
| **Provider Name\*** |
| **Provider Address\*** |  |

**Patient Information**

|  |  |
| --- | --- |
| **Patient Name\*** | **Date of Birth\*** |

**Medication Information**

|  |  |
| --- | --- |
| **Medication Name\*** | **Strength/Dosage\*** |

**Description of Dispute and Requested Outcome/**500-character limit (Additional documentation may be attached as needed) \*

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Contact Name Title Phone Number

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Signature Date Fax Number