**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) \*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name Title Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Fax Number