Prime Healthcare

MEDICATION APPEAL REQUEST

INSTRUCTIONS:

- Complete the form below. **Fields with an asterisk (*) are required.**
- **Include:**
  - **SlateRx denial letter***
  - **Letter of appeal explaining why medication is necessary***
  - **Supporting clinical documentation***

Mail or Fax completed form and attachments to:

SlateRx
Attn: Appeals Department

Fax: 866-351-1617
Mail: P.O. Box 608
Hudson, OH 44236

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 ______

Rev. 07/01/2025