PROVIDER RECONSIDERATION (APPEAL) FORM

This form is used to request an appeal for providers after a coverage determination or prior authorization has been denied.

DRUG REQUESTED: ______________________________

QUANTITY: ______________________________

DIAGNOSIS: ______________________________

Complete all fields, attach appropriate documentation, and mail or fax to:

True Rx Health Strategists
Attn: Provider Appeals
Phone: 866-921-4047
Fax: 812-254-7426
P.O. Box 431
2495 E. National Hwy.
Washington, IN 47501

Check Reason for Reconsideration:

- ☐ Prior authorization not requested.
- ☐ Authorization does not cover services rendered.
- ☐ Prior authorization denied.

Date: ______________ Provider Name: ______________

NPI: ______________ Phone: ______________ Fax: ______________

Address: ______________________________

City, State, Zip Code: ______________________________

PATIENT NAME: ______________ DATE OF BIRTH: ______________

PATIENT ID#: ______________ DATE(S) OF SERVICE: ______________

PA Case #, Reference, or Rx#: ______________________________

REQUEST FOR REVIEW:

Please explain why this medication is medically necessary for the patient:

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The following attachments may be required:

1. Supporting documents (medication history, diagnostic workup, lab results, chart notes, etc.)
2. Original request information
3. Denial notification

Signature of person requesting the appeal (the enrollee, or the enrollee's prescriber or representative):

______________________________ Date: ______________