APPEAL REQUEST FORM

PREScriber Information

Name

Specialty  DEA / NPI

Phone  Fax

Pharmacy Information

Name

Phone  Fax

Patient Information

Name

Date of Birth  Member ID

Medication Information

Name: __________________________  Strength: __________________________
Quantity: __________________________  Dosing: __________________________
Diagnosis: __________________________
Duration of Therapy: __________________________
REQUESTOR Information

Name of person filing this appeal: ________________________________

Relationship to Patient: ________________________________

Covered Person Patient Authorized Representative
(Please circle one)

Contact Information of person filing appeal (if different from patient):

Address ________________________________ City / State / Zip

Phone ________________________________ Fax ________________________________

If person filing appeal is other than patient, patient must indicate authorization by signing here or providing patient’s consent form to act on patient’s behalf:

Signature ________________________________ Date ________________________________

URGENCY Information

Are you requesting an urgent appeal?  □ Yes  □ No

Reason for urgency (if “Yes”):

________________________________________________________

APPEAL Information

1. Briefly describe why you disagree with the prior authorization denial decision.

________________________________________________________
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<tr>
<th><strong>APPEAL Information (continued)</strong></th>
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2. Please provide the reason(s) the medication requested is medically necessary for the patient.

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3. Please provide other diagnosis(s), treatment(s) and comments to consider during the appeal review.

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Please attach any of the following documentation to support your appeal:

- A copy of the denial letter received from the Prior Authorization Department
- Physician letter in support of the appeal, or other supporting documentation
- Pertinent medical records
- Studies to support use in proposed treatment

*Information given on this form is accurate as of this date.*

Prescriber or Authorized Signature

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**Signature**  
**Date**

*The Appeal Request Form must be signed by a prescriber or other authorized medical personnel to be reviewed. I understand that the Prior Authorization Department’s use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).*
Memorial Hermann Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

All Commercial HMO products are underwritten by Memorial Hermann Commercial Health Plan, Inc. All Commercial PPO products are underwritten by Memorial Hermann Health Insurance Company. All Hybrid products are administered by Memorial Hermann Health Solutions, Inc.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).