Prior Authorization and Appeals Department
Phone: 800-711-4555
Fax: 844-403-1029

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.

APPEAL Information (continued)

2. Please provide the reason(s) the medication requested is medically necessary for the patient.

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

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

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).