

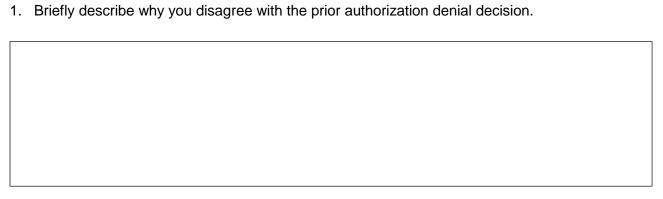
Prior Authorization and Appeals Department Phone: 800-711-4555 Fax: 844-403-1029

APPEAL REQUEST FORM

PRESCRIBER Informa	tion			
Name				
Specialty			DEA / NPI	
Phone	Fax			
PHARMACY Informati	on			
Name				
Phone	Fax			
PATIENT Information				
Name				
Date of Birth	Member ID			
MEDICATION Information	tion			
Name:		Strength:		
Quantity: _		Dosing:		
Diagnosis: Duration of Therapy:				

REQUESTOR Information

Name of person filing this appeal:					
Relationship to Patient:	Covered Person	Patient Authorized (Please circle one)	Representative		
Contact Information of person filing	appeal (if different from	n patient):			
Address		City / State /	Żip		
Phone	Fax				
If person filing appeal is other than p providing patient's consent form to a		dicate authorization by s	igning here or		
Signature		Date			
URGENCY Information					
Are you requesting an urgent appea	al? Yes	No			
Reason for urgency (if "Yes"):					
APPEAL Information					



APPEAL Information (continued)

2. Please provide the reason(s) the medication requested is medically necessary for the patient.				
 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 				
 A copy of the demanenter received from the Phot Authorization Department Physician letter in support of the appeal, or other supporting documentation Pertinent medical records 				
 Studies to support use in proposed treatment 				
Information divor on this form is approximate as of this data				

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).