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PRESCRIPTION DENIAL FORM

PART I - TO BE COMPLETED BY CLIENT/PATIENT

1) Name of Client/Patient_____Date of Birth:_____

2) Name and Address of Insurance Company:
_____ Phone: ( )_____

3) Date of Injury_____ CLAIM NUMBER *_____
***claim number for date of injury medication is related to/prescribed for**

Name and Address of Third Party Administrator for Prescriptions: _____
_____ Phone: ( )_____

INFO ON 3RD PARTY RX CARD: BIN#___ _____ ID#_____ ___Phone: ( )_____

4) Designated/Prescribing Primary Treating Physician_____

5) Medication denied:_____Date Prescribed:_____

Date denied:_____ Prescribing Doctor:_____

6) Name, Address and phone number of Pharmacy:_____
name
_____( )_____
address **phone**

PART II - TO BE COMPLETED BY PHARMACY STAFF ** Please note, Applicant's Attorney does not contact the 3rd Party Administrator for RX denials, the Pharmacy and/or the Client/Patient can contact them directly .

1) Do your records for this patient agree with the information set forth above? Yes_____ No_____

If "NO," what is different?_____
_____
_____

2) When did you first request authorization for the denied medication?_____

From whom did you request authorization? _____

If there is a written denial, please attach a copy.

Date of denial_____ Denial was made by: TELEPHONE E-MAIL FAX LETTER
circle one

Name of Individual_____ Name of Company _____

What reason was given for the denial? _____

_____

_____

Are you a provider for the 3rd Party Company ?_____

_____ _____
DATE: PHARMACY STAFF MEMBER'S NAME **please print**