'ohana health plan™

Medicare Medication Appeal Request

Please fax request to # 1-866-388-1766 along with all pertinent medical records.
Please contact the Customer Service department for any questions you may have.
Complete each section legibly.

The appeal request is being initiated by (please select only one option):

☐ Physician (or office staff member acting on behalf of physician). If requestor is not the prescribing physician, is the member aware of the appeals request and does the member approve? ☐ Yes ☐ No

☐ Member

☐ Appointed Representative

Member's Name:	Date of Request:	**Name person requesting this appeal and their relationship to the member:**
Member ID#:		**Original Coverage Determination Date:** **Ticket #:**
Date of Birth:		Requestor's Phone Number:
Member's Phone Number:		Requestor's address: *(if applicable)*
Member's Address:		
Diagnosis:		Requestor's Fax Number: *(if applicable)*
Medication Name:		Physician's Name:
Medication Strength & Dose:		Contact Person at Physician's office:
Quantity and Day Supply:		Physician Phone:
Length of Treatment being requested:		Physician Fax:
Clinical Reason for Appeal (include medical documentation)		
History/Allergies		

☐ **REQUEST FOR EXPEDITED REVIEW (72 HOURS)**
BY CHECKING THIS BOX, THE PRESCRIBING PHYSICIAN INDICATED ABOVE OR PHYSICIAN'S AGENT CERTIFIES THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA. Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.