# REQUEST FOR EXTERNAL FORMULARY EXCEPTION REVIEW

Name of Person Filing Exception Request: _____

Circle One: Member Provider Authorized Person

Requestor Address: _____
Requestor Telephone: _____ Fax Number: _____

Member Name: _____

Member ID#: _____ Member Date of Birth _____

Member Address: _____

_____

Member Phone Number: _____ Home Work Mobile
(Choose one)

**INSURANCE INFORMATION**

Insurer Name: _____

Covered Person Insurance ID Number: _____

Insurance Claim/Reference Number: _____

Insurer Mailing Address: _____

_____

Insurer Phone Number: (  ) _____

**HEALTH CARE PROVIDER INFORMATION:**

Treating Physician / Health Care Provider: _____

Provider Address: _____

_____

Contact Person: _____ Phone Number: (  ) _____

Medical Records Number (If Known): _____

**If requestor above is not the member or provider, by signing below I attest that I am giving the above person permission to file an appeal on my behalf.**

_____ _____

Member Signature: Date

Circle One: Standard Urgent

**Medication Name and Strength:**

- What is the member's diagnosis: _____

What is the current dosage for member (i.e. tablets daily, weekly, monthly)?

What medicines has the member tried and failed?

Reason member cannot try another medicine within their Covered Drug List?

Briefly describe why you disagree with this decision and/or why this request should be approved:

You may attach additional information, such as a prescriber's letter, bills, medical records or other documents to support your claim. Send completed form along with your denial notice to address below. Be sure to keep copies of this form, your denial notice and all documents and correspondence related to this claim.

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