allcare health™

allcare advantage
allcare cco
allcare pebb

Medication Request

☐ STANDARD Request (within 72 hours)

☐ URGENT Request (within 24 hours, as to not seriously jeopardize the member's health)
**REQUIRES PROVIDER JUSTIFICATION

INSURANCE INFORMATION

☐ AllCare CCO ☐ AllCare PEBB ☐ AllCare Advantage

MEMBER

First name ____________________ Last name ____________________

DOB ____________________ ID# ____________________

PROVIDER/PHARMACY

Prescribing provider (provide full name of provider) ____________________

Provider Phone ____________________ Provider fax ____________________

Pharmacy name ____________________ Pharmacy location ____________________

MEDICATION NAME AND STRENGTH | **DIAGNOSIS CODE(S) FOR MEDICATION (REQUIRED)**

1. ____________________ DX: ____________________
2. ____________________ DX: ____________________
3. ____________________ DX: ____________________
4. ____________________ DX: ____________________

How long has member been established on this med? ____________________ Length of need ____________

Have other treatments/medications been tried and failed? ☐ Yes ☐ No

If "Yes", list: ____________________

Additional information and/or comments:

PREPARED BY

Name ____________________ Phone ____________________

Clinic name ____________________ Date ____________________

FAX COMPLETED FORM WITH SUPPORTING DOCUMENTATION TO (541) 471-4128

** Payments of benefits is contingent upon eligibility, prior authorization requirements, final diagnosis from the provider (OHP), and exclusions and limitations of the contract.

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Medford 3629 Aviation Way, Medford, OR 97504 Tel (541) 734-5520
Toll-free 1 (888) 460-0185 TTY 1 (800) 735-2900 Fax (541) 471-3784 **AllCareHealth.com**