

MEDICATION REQUEST FORM

- STANDARD REQUEST (within 72 hours)
 EXPEDITED REQUEST (as to not seriously jeopardize the member's health)(within 72 hours)
****REQUIRES PROVIDER JUSTIFICATION:**

INSURANCE PLAN: AllCare CCO

MEMBER:

First Name: _____ Last Name: _____
DOB: _____ ID #: _____

PROVIDER/PHARMACY:

Prescribing Provider: _____
(please provide full name of Provider)

Provider Phone: _____ Provider Fax: _____

Pharmacy Name: _____
(please include location)

Pharmacy Phone: _____ Pharmacy Fax: _____

MEDICATION NAME AND STRENGTH: ICD-10 CODE (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: _____ Clinic name: _____ PH: _____

Fax: _____ Date: _____

**PLEASE FAX COMPLETED FORM WITH SUPPORTING DOCUMENTATION
TO 541-471-4128**

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