BLUECROSS BLUESHIELD
PRESCRIPTION DRUG APPEAL FORM

This form must be completed by the prescriber. Because of the protected health information (PHI) contained herein, this form will be used only for purposes related to provision of treatment, payment and health care operations (TPO). This form and its contents are permissible under HIPAA. HIPAA does not restrict the communication of PHI to providers for TPO-related purposes.

Patient Information	
Date of Request	Member Name:
Member ID #:	Date of Birth:
Provider Information	
Prescriber's Name:	Prescriber's DEA #/Specialty:
Phone:	Fax:
Office Address:	

Medication/Dose Requested:	
To complete our review and to make an appropriate determination, the following information must be provided about your appeal for the patient and medication listed above.	
Diagnosis:	ICD-9 Code
Previous drug treatment/history:	
Other relevant patient information:	

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date

The prescriber signature must be completed. Requests will not be reviewed if this field is incomplete.

FAX COMPLETED FORM TO 803-264-0258.