Medicare Coverage Review Request Form

35045

To initiate a coverage review for your patient, please fax us this completed form. Please note that the completion of this form does **not** constitute completion of the coverage review process and is not a guarantee of benefit coverage. Upon receipt of this completed form, Medco will fax you the appropriate questionnaire. If your request is faxed 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday, you can expect the questionnaire faxed to you within 24 hours of your request. If the request is received outside of these time frames, the questionnaire will be faxed to you the next business day. Once the completed questionnaire is returned to Medco, a coverage decision will be faxed to you within 1 business day.

If your request is urgent or if you have questions, contact us toll-free at 1-800-753-2851.

PATIENT INFORMATION

Last name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

First name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of birth: |__|__|/|__|__|/|__|__|__|__| Telephone: |__|__|__|-|__|__|__|-|__|__|__|__|

Medco Member ID number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__| State: |__|__| Zip: |__|__|__|__|__|

MEDICATION (that requires a coverage review)

Medication name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Strength: |__|__|__|__|__|__|__|__|__|__|__| & Qty.: |__|__|__|__|__|__|__|__|__|__|

Directions (SIG.): |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

PRESCRIBER INFORMATION

Last name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

First name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Office address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__| State: |__|__| Zip: |__|__|__|__|__|

SECURE fax : |__|__|__| - |__|__|__| - |__|__|__|__| Telephone: |__|__|__| - |__|__|__| - |__|__|__|__|

Signature: _____ Date: _____

FAX COMPLETED FORM TO 1-800-837-0959. (Please do **not** send with a cover sheet.)

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Location: Nevada (15) **Case Id: 9999999**

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