



Minnesota Health Care Programs (MHCP)

Prescription Drug Reconsideration Request Form

Fax to: (866) 648-4574 Health Information Designs, Inc. 391 Industry Drive Auburn, AL 36832 (866) 205-2818 (phone)

Recipient Information

Form with fields: RECIPIENT NAME, RECIPIENT ID NUMBER, CITY, STATE, DATE OF BIRTH (MM/DD/YYYY)

Provider Information

Form with fields: PROVIDER NAME, NPI, CITY, STATE, PHONE NUMBER, PROVIDER SIGNATURE, DATE, FAX NUMBER

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Pharmacy Information

Form with fields: DISPENSING PHARMACY, NPI, CITY, STATE, PHONE NUMBER

Request Information – Provide a copy of the original prior authorization request and denial letter.

Form with fields: DATE OF ORIGINAL REQUEST, ORIGINALLY REQUESTED BY (Prescriber/Pharmacy), DATE OF DENIAL NOTIFICATION, IS ADDITIONAL INFORMATION BEING SUBMITTED? (Yes/No)

Requester is encouraged to submit any additional information to support the request for appeal including, for example, clinic notes and dates of previous medication trials.

Rationale/Medical Reason for Disagreement (attach additional documentation if needed)

Large empty text box for rationale/medical reason for disagreement.

FOR HID USE ONLY

Form with fields: DETERMINATION (Approved/Denied Notification), SENT TO (Prescriber/Pharmacy), DATE SENT

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipients and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (866) 205-2818 or fax (866) 648-4574 and destroy all copies of the original message.