

## APPEAL REQUEST FORM

Please send the completed Appeal Request form and any additional information to RxAdvance by fax:  
**508-452-0076** for standard requests  
**508-452-6421** for expedited requests

**Note:** Please provide as much information as possible on this form. Missing data may cause processing delays. Attach additional sheets to this form, if necessary. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary as per plan policy and procedures.

**Who May Make an Appeal Request:** The member, their prescriber, or their authorized representative may file an appeal within 180 days (6 months) of receiving notice that a claim or service was denied. If a prescriber appeals on behalf of the member, RxAdvance will not request approval from the member to proceed. If another individual (i.e. family member, friend, or attorney) files an appeal on behalf of the member, the member must complete the Authorized Representative form. The member can contact RxAdvance to learn how to name an authorized representative.

Member Information	
<b>Member Name</b>	
<b>Member Health Plan</b>	
<b>Member ID #</b>	
<b>Member Date of Birth</b> (MM/DD/YYYY)	
<b>Member Phone</b>	

Requestor Information (Complete this section <u>ONLY</u> if the Requestor is not the member)	
<b>Requestor Name</b>	
<b>Requestor Relationship to Member</b>	
<b>Requestor Address</b>	
<b>Requestor Phone</b>	

Drug Information	
<b>Prior Authorization #</b> (i.e. Request ID)	
<b>Drug Name &amp; Strength</b>	
<b>Have you purchased the drug pending the appeal?</b> If yes, you must attach a copy of your receipt as proof of payment AND provide the information requested in this table below	Yes      No
<b>Date of Purchase of Drug</b> (MM/DD/YYYY)	
<b>Amount Paid for Drug</b>	

**Prescriber Information**

<b>Prescriber Name</b>	
<b>Prescriber Address</b>	
<b>Prescriber Phone</b>	
<b>Prescriber Fax</b>	
<b>Office Point-of-Contact</b>	

**Explanation of Appeal Request**

Please explain your reason(s) for appeal. Attach additional sheets to this form, if necessary. Attach any additional information you believe that may help your case, such as medical records or a statement from your prescriber. Input from your prescriber will be needed to explain why you cannot meet the plan’s coverage criteria and/or why the drugs required by the plan are not medically appropriate for you.

**Important Information and Timelines**

All documentation submitted, regardless of whether this information was submitted previously, will be reviewed. RxAdvance will respond in writing to you and/or your authorized representative with a letter explaining the decision of the appeal. An explanation for modifying or upholding the original decision will be included.

If your appeal is for a drug or service that you have not yet received, your appeal will be completed within 30 days of receipt. If your appeal is for a drug or service that you have already received, the appeal will be completed within 60 days of receipt.

**Expedited Requests:** If you or your prescriber believe that your health may be in serious jeopardy, or if your prescriber believes you may experience pain that cannot be adequately controlled while waiting for your appeal decision, you can request an expedited appeals decision. An expedited appeals decision will be made in 72 hours. If you do not provide a statement showing your prescriber’s support of an expedited appeal, RxAdvance will determine if the request meets expedited requirements. An expedited appeal will not be permitted for a drug that has been purchased already and for which reimbursement is being requested.

Check this box if you believe a decision is needed within 72 hours.

**Signature of Requestor**

<b>Signature of Requestor</b>	
<b>Date</b>	

**IMPORTANT:** Keep copies of this form and all documentation submitted with this request.

The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution or copying is strictly prohibited. If you have received this information in error, please notify us immediately and destroy this document.