



MEDICARE EXCEPTION REQUEST FORM

****Please note that this form is to be completed by the prescribing physician.** This form and its contents are permissible under HIPAA, as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment, and healthcare operations (TPO). HIPAA does not restrict the communication of PHI with providers for TPO related purposes.

Date of Request:

Case #:

Member Name:	Date of Birth:
Member ID Number:	Sponsor:
Physician Name:	DEA #:
Physician Phone Number:	Physician Fax Number:

Medication:

We have received your request for an exception for the patient and medication listed above. ***In order to complete our review and make an appropriate determination the following information will be necessary:***

Diagnosis: _____

Previous medication treatment history: _____

Physician Signature: _____ **Date:** _____

****Physician signature field must be completed. Requests will not be reviewed in the event that this field is incomplete.
Please call (800) 311-0594 for assistance in filling out this form (Dr. office only). Most requests are processed within one business day of receiving complete information. However, some requests may require more time to review.

PLEASE FAX ONLY THIS COMPLETED FORM TO PHARMACARE AT (800) 373-0238