

**FAX TO : 1-800-459-2135**

Health Information Designs, Inc.  
P.O. Box 320506  
Flowood, MS 39232  
Phone 800-355-0486

**APPEAL/ RECONSIDERATION  
REQUEST FORM**

**BENEFICIARY INFORMATION**

Beneficiary's Name: \_\_\_\_\_ Beneficiary's Medicaid # \_\_\_\_\_

DOB: \_\_\_\_\_ City \_\_\_\_\_  
Month Day 4-Digit Year

**PRESCRIBER INFORMATION**

Prescribing Physician: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

NPI #: \_\_\_\_\_

Medicaid ID # \_\_\_\_\_

Phone #: \_\_\_\_\_

FAX #: \_\_\_\_\_

\_\_\_\_\_  
Physician's signature and date

*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**

Dispensing Pharmacy: \_\_\_\_\_

Provider # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Phone #: \_\_\_\_\_

FAX #: \_\_\_\_\_

**REQUEST INFORMATION**

Date of Request: \_\_\_\_\_ Requested By: Physician \_\_\_ Pharmacy \_\_\_ Beneficiary \_\_\_

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

**RATIONALE/MEDICAL REASON FOR DISAGREEMENT**

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FOR HID USE ONLY	
Determination: Approved _____	Denied _____
Notification Sent to: Physician _____ Pharmacy _____ Beneficiary _____	
Date Sent: _____	