

FAX TO: 1-800-459-2135

HEALTH INFORMATION DESIGNS, INC.
P.O. BOX 320506
Flowood, MS 39232
Phone: (800) 355-0486

**EARLY REFILL
DUR OVERRIDE 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 #: _____

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.

Physician's Signature and date

PHARMACY INFORMATION

Dispensing Pharmacy: _____

City: _____ State: _____

Provider ID# _____

Phone #: _____

Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____

Quantity/Month: _____

NDC#: _____

Maximum Qty: _____

Reason for Request

- ____ Physician increased the dosing frequency
- ____ Physician increased the number of units per dose
- ____ New Admission to Nursing Home
- ____ Extra medication needed to stop or mitigate further morbidity due to acute clinical condition
- Explanation: _____
- ____ Other, Specify: _____

***Supporting documentation must be available in the patient record

Note: No early refill can be authorized if the beneficiary's monthly service limit has been reached.

*The pharmacist should maintain documentation for each early refill override that is obtained from HID.

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____

Denied/Code: _____

From Date: _____ Thru Date: _____

Reviewed by: _____

HID# _____ PA# _____