

FAX TO: 1-800-459-2135

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

**MAXIMUM UNIT 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 and Strength: _____ Maximum Quantity Requested: _____

Diagnosis: _____ NDC: _____

Medical Justification: _____

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

FOR HID USE ONLY

Eligibility Verified by _____
Approved _____ Denied/Code: _____
From Date _____ Thru Date _____
Reviewed by _____
HID# _____ PA# _____

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