HEALTH PLUS OF NEW YORK

Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department

10680 Treena Street, Suite 500
San Diego, CA 92131
Phone: 1-800-788-2949
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain prior authorization. Please complete this form and fax to Med**Impact** Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact Med**Impact**'s Customer Service at (800) 788-2949.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Name (required):	Patient's Health Plan (required):
Patient ID # (required):	Physician Name/Specialty: Physician ID#/DEA #::
Patient DOB (required):	Physician Area Code and Telephone Number (required): ( ) -
Diagnosis (required):	Physician Area Code and Fax Number (required): ( ) -
Pharmacy used by Member:	Pharmacy Area Code and Telephone Number: ( ) -
Drug Requested:	Quantity (per month):
Dose:	Length of Treatment (**please be specific**):
Strength:	Dosage Form (e.g. Oral, Injection):
Reason for Medication Request (**please be specific, give detail**):	
Other Medications Tried and/or Failed (**please be specific, give detail**):	
Other Pertinent History (relative or pertaining to this request):	