RxAdvance

APPEAL REQUEST FORM

Please send the completed Appeal Request form and any additional information to RxAdvance by fax:
508-452-0076 for standard requests
508-452-6421 for expedited requests

Note: Please provide as much information as possible on this form. Missing data may cause processing delays. Attach additional sheets to this form, if necessary. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary as per plan policy and procedures.

Who May Make an Appeal Request: The member, their prescriber, or their authorized representative may file an appeal within 180 days (6 months) of receiving notice that a claim or service was denied. If a prescriber appeals on behalf of the member, RxAdvance will not request approval from the member to proceed. If another individual (i.e. family member, friend, or attorney) files an appeal on behalf of the member, the member must complete the Authorized Representative form. The member can contact RxAdvance to learn how to name an authorized representative.

Member Information	
Member Name	
Member Health Plan	
Member ID #	
Member Date of Birth (MM/DD/YYYY)	
Member Phone	

Requestor Information (Complete this section ONLY if the Requestor is not the member)	
Requestor Name	
Requestor Relationship to Member	
Requestor Address	
Requestor Phone	

Drug Information	
Prior Authorization # (i.e. Request ID)	
Drug Name & Strength	
Have you purchased the drug pending the appeal? If yes, you must attach a copy of your receipt as proof of payment AND provide the information requested in this table below	◯ Yes ◯ No
Date of Purchase of Drug (MM/DD/YYYY)	
Amount Paid for Drug	

RxAdvance

Prescriber Information	
Prescriber Name	
Prescriber Address	
Prescriber Phone	
Prescriber Fax	
Office Point-of-Contact	

Explanation of Appeal Request

Please explain your reason(s) for appeal. Attach additional sheets to this form, if necessary. Attach any additional information you believe that may help your case, such as medical records or a statement from your prescriber. Input from your prescriber will be needed to explain why you cannot meet the plan's coverage criteria and/or why the drugs required by the plan are not medically appropriate for you.

Important Information and Timelines

All documentation submitted, regardless of whether this information was submitted previously, will be reviewed. RxAdvance will respond in writing to you and/or your authorized representative with a letter explaining the decision of the appeal. An explanation for modifying or upholding the original decision will be included.

If your appeal is for a drug or service that you have not yet received, your appeal will be completed within 30 days of receipt. If your appeal is for a drug or service that you have already received, the appeal will be completed within 60 days of receipt.

Expedited Requests: If you or your prescriber believe that your health may be in serious jeopardy, or if your prescriber believes you may experience pain that cannot be adequately controlled while waiting for your appeal decision, you can request an expedited appeals decision. An expedited appeals decision will be made in 72 hours. If you do not provide a statement showing your prescriber's support of an expedited appeal, RxAdvance will determine if the request meets expedited requirements. An expedited appeal will not be permitted for a drug that has been purchased already and for which reimbursement is being requested.

☐ Check this box if you believe a decision is needed within 72 hours.

Signature of Requestor	
Signature of Requestor	
Date	

IMPORTANT: Keep copies of this form and all documentation submitted with this request.