



**HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

Member Reimbursement - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Expedited/Urgent

Drug Name:

Strength:

Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. What is the amount requested for reimbursement?

Q2. What is/are the dates of fill?

Q3. Is/are there receipts attached?

Yes No

Q4. Is/are the medications formulary? If not, a coverage determination will have to be made.

Yes No

Q5. Additional Information:

Prescriber Signature

Date