APPEALS FORM
Re: Office of Group Benefits (OGB) August 1st Prescription Plan Changes for Active Employees and Retirees without Medicare

If your prescription claim(s) rejected or denied at your pharmacy in August/September 2014, you may request an appeal by completing this form.

INSTRUCTIONS

Please read carefully before completing this form. **Forms without the required information cannot be processed and will be returned to sender.**

Part 1: Member Information (to be completed by the member)

1. Complete all information under Part 1. The member ID Number is located on your insurance card.
2. Please submit a separate form for each patient and pharmacy from which you purchase medications.
3. **IMPORTANT NOTE: Payment and related correspondence will be sent to the insured member unless you provide us with an Alternate Address in Part 1.**

Part 2: Receipt Information

1. Submit prescription receipts/labels that contain the requested information (shown below) or have your pharmacist complete Part 2 and Part 3. If you do not receive a receipt for your prescription(s), pharmacist signature is required.
2. Include all original pharmacy receipt(s). Tape receipts to a separate page to be submitted with the form. Note: Please do not staple receipts or other documentation to the form.
3. For multiple claims, please submit a separate Part 2 for each medication or use the multiple prescription alternative form.

PRESCRIPTION/PHARMACY INFORMATION

Prescription Label Example: Please use this example as a guide to locate the required information. Note: Each pharmacy may have a unique label format.

Anytime Pharmacy #1234 (509)555-1234
123 Any Street **Store NPI: 1234567890**
Home Town, US 12345-6789

RX 1234567 **Date Filled: 1/1/2009**

DOE, JANE
DOB: 01/01/1900
456 Home Road (509)555-5678
Home Town, US 12345

Amoxicillin 500 mg capsules (Teva) **DAW: 0**
00000-1111-22 **QTY: 45** **Days Supply: 30**

A. SMITH, MD
NPI: 4567890123

U&C: 200.00 **COPAY: 20.00**

1. Date Filled*
2. RX Number
3. Quantity*
4. Day Supply*
5. National Drug Code (NDC)*
6. Medication Name and Strength*
7. Physician Name
8. Physician National Provider ID (NPI)
9. DAW
10. Usual and Customary Price (U&C)/RX Price*
11. Copay*
12. Pharmacy National Provider ID (NPI)

*****_REQUIRED INFORMATION - CLAIM WILL BE RETURNED IF THIS INFORMATION IS NOT SUPPLIED._

Part 3: Pharmacy Information (To be completed by the pharmacy)

1. If required information is not available on the receipt, ask your Pharmacist to complete Part 2 and Part 3.
2. Remember to keep a copy of the completed form and receipt(s) for your records.
3. Send the completed form and receipt(s) to: MedImpact Healthcare Systems, Inc.

OGB August 1st Plan Changes APPEAL
PO Box 509098
San Diego, CA 92150-9098
Fax: 858-549-1569
E-mail: Claims@Medimpact.com

Office of Group Benefits (OGB) Appeals Form

PART 1

***Indicates required information**

Primary Member ID Number*	Group Number	
Name of Plan/Insurance	Primary Subscriber Name*	DOB: (mm/dd/yyyy)* / /
Patient Name: (First, Middle, Last)*	Date of Birth: (mm/dd/yyyy)* / /	Relationship to Insured Self ☐ Spouse ☐ Dependent ☐
Insured Address: (Street, City, State, Zip code)		
Alternate Address: (Street, City, State, Zip code) ***If no alternate address is specified, correspondence and/or payment will be forwarded to the primary subscriber address on file with your health plan/insurance.**		
Member Signature*	Telephone Number ( )	Date

PART 2

RX Number	Date Filled*	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /				

Medication Name and Strength *	Physician Name & NPI Number	RX Price*	Co-Pay*
	Name: _____ NPI : _____	$	$

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

RX Number	Date Filled *	New ☐ Refill ☐ (check one)	Quantity*	Day Supply*	National Drug Code (11 Digit)*
	/ /				

Medication Name and Strength *	Physician Name & NPI Number	RX Price*	Co-Pay*
	Name: _____ NPI : _____	$	$

Compound? ☐ Yes ☐ No (If yes, please identify NDC ingredients & quantity amounts on the Compound Claim Form)

PART 3

Affix Pharmacy Label Here or Enter the Required Information:

Pharmacy Name*			Pharmacy Telephone Number	
Street Address			NPI*	
City	State	Zip	Pharmacist Signature*	Date*

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