PART D PRESCRIPTION DRUG APPEAL FORM

To initiate an appeal, complete and submit this form to: ATRIO Health Plans - Part D Appeal by Fax: 866-877-2061
Or by Mail: 550 Hawthorne Ave SE #140, Salem, OR 97301

Date: _____ PA Reference # (found on denial letter): _____

Member Information

Name: _____ ____ _____ DOB: _____/_____/_____
First Name MI Last Name

Group/Health Plan Name: _____ Group/Health Plan Id #:_____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Physician Information (name and phone number are required)

Name: _____ _____ Physician ID#: _____
First Name Last Name

Address:_____ City: _____ State: _____ Zip:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____ DEA#: _____

Appeal Information /Description of Appeal

Date drug was denied: _____ Drug name, strength, and duration denied: _____

Provide a detail description of the reason for this appeal (attached additional sheets if necessary):_____

_____

_____

_____

_____

Authorized Representative Information

If someone other than the member is filing this appeal they may need to submit documentation of your authority to appeal on the members behalf. Please Provide The Following Information:

Name (first and last):_____ Relationship to Member: _____

Address:_____ City: _____ State: _____ Zip:_____

Daytime Telephone: (_____)_____-_____

Submitter Name: _____ Submitter Phone: _____

Important Note: Expedited Decisions

If you believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS.

Expedited appeal requests can also be made by phone at 1-877-672-8620 (TTY 711), daily from 8 a.m. to 5 p.m. local time.

For additional information, please go to https://atriohp.com