Prior Authorization Appeal Form

If you wish file an appeal, please contact the Customer Service Center at (800) 460-8988. If you do not have access to a phone, you can complete this form or write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Prior Authorization Appeal
US Script, Inc.
2425 W. Shaw Ave.
Fresno, CA 93711

Or fax to Medicaid, Medicare, & Ambetter
(866) 399-0929
Commercial (844) 262-7263

Please note: You must submit, in writing, comments, documents, records or other information relevant to the appeal. If you decide to appeal this adverse decision, it will have no effect on your rights to any other benefits under your plan. Your benefit plan design, including co-payments, prior authorization requirements, and formulary, are all determined by your prescription plan sponsor.

I. MEMBER INFORMATION		**II. PRESCRIPTION PLAN INFORMATION**
Member Name/Provider Name:		Insured Member's ID:
Address:		Group #:
Birth Date:	Phone:	Plan Sponsor:
III. SUBMITTER'S INFORMATION		
Date and Time of Submission:		
Submitter's Name/Title:		Submitter's Phone:

Please check one: Standard Appeal ☐ or Expedited Appeal ☐

A standard appeal is a request to change an adverse decision with no imminent or serious threat to member's health.

An expedited appeal is available when the adverse determination may result in an imminent or serious threat to the member's health and:

1. Involves continued or extended health care services, procedures, or treatments; OR
2. Involves additional services for a course of continued treatment prescribed by a health care provider; OR
3. Home care following inpatient admission; OR
4. The health care provider believes an immediate appeal is warranted.

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Describe reasons for the appeal: (Please state all details relating to the matter in question, including names, dates, places, etc. Please attach additional sheets of supporting documentation about your appeal, if necessary and applicable.):