

Pharmacy Provider Reconsideration Request Form

Fax to
503-416-1428

Information required for processing this request:

- All fields must be completed and the information must be legible.
- Provide documentation supporting your statement (e.g. medical records and clinical studies.)
- Provide a statement of why you disagree with the original denial reason and/or why you disagree with the criteria we used to make the original decision.

Determinations for Oregon Health Plan members will be rendered within 16 days from the date received. For assistance with this form call CareOregon at 503-416-4100 from 8 a.m. to 5 p.m., Monday through Friday.

Note: Provider Reconsideration Request must be received within 60 days from the date of the original denial of the medication.

Patient Information

Patient Name:

Date of Birth:

Member ID:

Phone:

Prescribers Information

Prescriber Name:

Contact Person:

Office Phone:

Office Fax:

Medication Information

Medication:

Date of Denial:

Additional Diagnosis Code(s) (ICD-10):

Reason given for original denial (check all that apply):

Age or Quantity Limit Exceeded
Experimental/Investigational Use

Below the Line Diagnosis
Insufficient Information

Does Not Meet PA Criteria
Non-Formulary Other

Rationale for Request

Provide a statement that explains why you disagree with the original denial or with the criteria we used in our determination. Please provide documentation supporting your statement (e.g. medical records and clinical studies).

Prescriber's Signature: _____ Date: _____

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