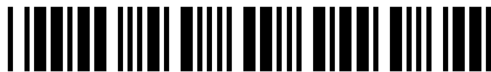
35045 

medco®

Coverage Review Request Form

Please complete all requested information and **fax** to Medco at **1-800-837-0959.**

If you have any questions, you may contact us toll-free at 1-800-753-2851.

PATIENT INFORMATION

❑ Yes ❑ No Is this patient enrolled in Medicare Part D?

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of Birth: |__|__|/|__|__|/|__|__|__|__| Telephone: |__|__|__|-|__|__|__|-|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug Name and Strength: ____ Qty: ___________

Directions (SIG.):____

Diagnosis: ____

PRESCRIBER INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Suite: |__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|

SECURE Fax: |__|__|__| - |__|__|__| - |__|__|__|__| Telephone: |__|__|__| - |__|__|__| - |__|__|__|__|

Prescriber's Signature: ____

FAX COMPLETED FORM TO 1-800-837-0959. (Please do **not** send with a cover sheet.)

Location: Nevada Call Center (15) Case Id: 9999999

Confidentiality Notice: This communication and any attachments are intended solely for the use of the addressee named above and contain confidential and legally privileged information. If you are not the intended recipient, any dissemination, distribution or copying is strictly prohibited. If you receive this communication in error, please notify Medco by fax or phone immediately. ***Medco facsimile machines are secure and in compliance with HIPAA privacy standards.*** *THE PROVISION OF THE INFORMATION REQUESTED IN THIS FORM IS FOR YOUR PATIENT'S BENEFIT. MEDCO DOES NOT COMPENSATE FOR COMPLETING THIS FORM.*

Form 001-W v4.0

© 2012 Medco Health Solutions, Inc.
All rights reserved.