Magellan Rx MANAGEMENT

Evry Health

Request for an Appeal

Today's Date: ______________

MEMBER INFORMATION

Last Name: ____________________ First Name: ____________________

Group Number: ____________________ Member ID Number: ____________________

Date of Birth: ____________________ Sex: ☐ Male ☐ Female

Street Address: ____

City: ____________________ State: __________ ZIP Code: ____________

PRESCRIBER INFORMATION

Last Name: ____________________ First Name: ____________________

Prescriber NPI: ____________________ Specialty: ____________________

Street Address: ____

City: ____________________ State: __________ ZIP Code: ____________

Prescriber Phone: ____________________ Prescriber Fax: ____________________

PERSON REQUESTING THE APPEAL

Last Name: ____________________ First Name: ____________________

Relationship to Member (e.g., Self, Mother, Father, Physician, Attorney, Other):

____

If a Provider, Federal Tax Identification Number: ____________________

Street Address: ____

City: ____________________ State: __________ ZIP Code: ____________

Requester Phone: ____________________ Requester Fax: ____________________

Form continued on next page.

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Request for an Appeal

Last Name: ______________________________ First Name: ____________________________

APPEAL INFORMATION

Reason for Requested Appeal:

☐ Attachments

Requester Signature: ____________________________________ **Date:** ________________
(required)

Return this form to:

Magellan Rx Management
4801 E. Washington Street
Phoenix, AZ 85034

Phone: 833-605-0625
Fax: 866-291-3727

You do not have to complete this form to have your appeal reviewed, but the form will help us with the appeal.

If you have any questions concerning this process, please feel free to call Magellan Rx Management for information.