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Evry Health

Independent Review Request Form

To request a review by an Independent Review Organization (IRO), complete this form in full and return it to Magellan Rx. You may also be required to complete a separate notice authorizing Magellan Rx to release to the IRO any available and necessary medical records and other documents relevant to the review.

Today's Date: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID Number: _____ Date of Birth: _____

Member Phone Number: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

PROVIDER INFORMATION

Last Name: _____ First Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber NPI: _____ Specialty: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

REQUESTER INFORMATION

Last Name: _____ First Name: _____

Requester Phone: _____ Requester Fax: _____

Form continued on next page.

Independent Review Request Form

Last Name: _____ First Name: _____

SERVICE INFORMATION

Date(s) of Service (if services have already been performed): _____

Describe the health care services for which benefits are being denied:

☐ Attachments

Requestor Signature: _____ **Date:** _____
(required)

Please describe your relationship to the patient and your authority to act on behalf of the patient in making a request for an independent review. You may be asked to provide us with the relevant legal document giving you this authority, if applicable.

Relationship to the patient (required): _____

If you have any questions about anything on this form, or how to fill it out, we can help. Please call 833-605-0625.

Please fax this form with supporting documentation to Magellan Rx Management at 866-291-3727, or mail it to:

Magellan Rx Management
Attn: IRO Request
4801 E. Washington Street
Phoenix, AZ 85034