AULTCARE AULTRA

HEALTHCARE REFORM COPAYMENT WAIVER REQUEST ENROLLMENT FORM

PATIENT INFORMATION

Patient Name		☐ Male ☐ Female	Allergies ☐ NKDA
Date of Birth	SSN#	Weight ☐ lb ☐ kg	Date
Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Email Address	

INSURANCE INFORMATION

Primary Insurance	Policy Holder
Group Number	Policy Number

Service is ☐Routine/Non-Urgent ☐Expedited/Urgent*

*Definition of expedited/urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside this definition should be submitted as routine/non-urgent.

MEDICAL INFORMATION (Please answer all questions to prevent a delay in the patient's therapy.)

Medication Name	Strength
Directions	

☐Requesting brand name ☐Continuation of therapy

What is the patient's diagnosis for the medication being request?

ICD-10

Please list the medication(s) the patient has tried and had an inadequate response. (Please specify all medications/strengths tried, length of trial, and reason for discontinuation of medication.)

MEDICAL INFORMATION (Please answer all questions to prevent a delay in the patient's therapy.)

Please list the medication(s) the patient has contraindication or intolerance. (Please specify all medications/strengths with the associated contraindication to or specific issues resulting intolerance to each medication.)

Are there any supporting labs or test results? (Please specify.)

QUANTITY LIMIT REQUEST

What is the quantity requested per day?

What is the reason for exceeding the plan limitations?

☐Titration or loading dose purposes

☐Patient is on dose-alternating schedule (i.e. one tablet in the morning and two tablets at night, one to two tablets at bedtime)

☐Requested strength/dose is not commercially available

☐Patient requires a greater quantity for the treatment of a larger surface area (topical applications only)

☐Other

Are there any other comments, diagnosis, symptoms, medications tried and failed, and/or information the physician believes is important to this review?

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name	Office Contact		Institution
Phone Number	Fax Number		Specialty
Address	City	State	Zip Code

Physician Signature ______________________________ Date ____________