FORM # FRX005

Standard Re-Determination Request Form

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval:

1. Name of the drug for the being request:_____
2. What is the diagnosis of the patient?_____
3. What is the reason for the re-determination request_____
   _____

(May send any additional documentation to support this request.)

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received_____

Reference Number_____

Approved / Denied (Circle One) by _____ Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

FOX Rx Care
We take your coverage personally.