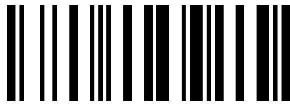

Patient Safety Through Innovation
Fax to: (251) 625-6502 OR (866) 478-7909
Attn: Admissions & Billing Departments

FACILITY RESPONSIBILITY REQUEST FORM
FOR A DRUG THAT HAS PRIOR AUTHORIZATION REJECT

The pharmacy has received a request for a medication and /or item(s) that are not covered by the payer source. A prior authorization must be obtained by the doctor. We have provided this information to the doctor.
In order for the pharmacy to dispense this medication and/or item(s), a signature authorizing payment is needed. By doing so, the facility is accepting charges for the medication and/or item(s) listed.

MEDICATION CAN NOT BE DISPENSED UNTIL PAYMENT OR PRIOR AUTHORIZATION HAS BEEN OBTAINED.

FACILITY: ____

Date

Patient's Name: ____
Last First MI

Date of Birth: ____

Payer Source: ______________________________

Medication / Item: ______________________________Qty:________ $________

Covered Alternatives: ____

Please note that all payment authorizations are good for the life of the prescription unless otherwise requested.

Please complete the following information:

_____ YES – Facility will pay for drug:
Drug will be dispensed as written and billed to facility.

______NO - Facility will not pay for drug:
Drug will not be dispensed until prior authorization is received.

Facility Authorizing Agent's Name: ______________________________

Facility Authorizing Agent's Signature: ______________________________
Date: __________________

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