PEQUOT PRxN PHARMACEUTICAL NETWORK Appeal Request Form

Please refer to your Prescription drug ID card for cardholder and carrier/group numbers.	Cardholder Number	Carrier Number	Group Number

Cardholder First Name Middle Initial Last Name		Name of Health Insurer or Employer
Address		
City	State	Zip Code
Telephone Number Home		Work

PATIENT & PRESCRIPTION INFORMATION

Patient First Name Middle Initial Last Name		
Patient DOB Month Day Year	Gender Male ☐ Female ☐	Relationship to Cardholder Self ☐ Spouse ☐ Child ☐ Student ☐
Date Medication was Denied	Date Medication was Filled or Requested	Prescription Number New ☐ Refill ☐
Medication Name	Medication Strength	Quantity Dispensed Days Supply
Amount Paid for Medication $	Signature of Cardholder or Representative X _____	

PHYSICIAN INFORMATION

Physician Name First Last		
Address		
City State Zip Code		
Office Telephone Number Office FAX		

PHARMACY INFORMATION

Pharmacy Name		
Address		
City State Zip Code		
Pharmacy Telephone Number Pharmacy FAX Number		

Please attach the following documentation to support your appeal as applicable.

- ☐ A copy of the denial letter received.
- ☐ A copy of the payment receipt for your medication.
- ☐ Physician letter in support of the appeal.

Brief explanation/reason for the appeal:

Pequot Pharmaceutical Network
P.O. Box 3560
Mashantucket, CT 06338-3560

INSTRUCTIONS FOR COMPLETING THE APPEALS FORM

Please provide the following information about the Cardholder:

- Identification number
- Carrier and Group numbers, if known (may be found on the Prescription Drug Card)
- Full Name
- Employer name
- Current home address
- Home and work telephone numbers, including area code

Please provide the following information about the Patient and Prescription:

- The patient's full name, if different from the cardholder
- Patient's birth date
- Gender (Male or Female)
- The relationship of the patient to the Cardholder
- Date of medication denial, if known
- Date the medication was filled or requested
- Prescription Number, if patient has received the medication
- Indicate if medication is a new prescription or a refill
- Name of the medication and strength along with the quantity and days supply
- Amount paid from pharmacy receipt
- Signature of cardholder or the cardholder's representative

Please provide the following information about the Physician:

- Prescribing physician's or health care professional's first and last name
- Office address
- Office telephone number and fax number

Please provide the following information about the Pharmacy, if applicable:

- Pharmacy name
- Pharmacy address
- Pharmacy telephone number and FAX number

Please provide the following documentation and supporting information as applicable:

- A copy of the denial letter received
- A copy of the payment receipt for the medication
- Physician letter in support of the appeal
- An explanation or reason for the appeal

Please mail the completed form and supporting documentation to:

Pequot Pharmaceutical Network
PO Box 3560
Mashantucket, CT 06338