



Prior Authorization Department
 PO BOX 3214
 Lisle, IL 60532-8214
 T: (866) 715-0874
 F: (630) 328-2186

Prior Authorization Appeal Request Form

Patient Information (Please print legibly)																	
Please refer to your prescription drug ID card	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>							
Patient First Name	Middle Initial	Last Name	Prescription Plan														
Address	DOB	Gender	Cardholder Relationship														
City	State	Zip Code															
Telephone Number	Home	Work															
Signature of cardholder or Representative		Clearly Print Cardholder Name															
X _____		_____															
Medication Information		Physician Information															
Date Medication Was Denied	Date Medication Requested	Physician Name															
		Last	First														
Medication Name		Address															
Medication Strength		City	State														
		Zip															
Quantity Requested	Day Supply Requested	Office Phone Number															
		Office Fax Number															
Please attach the following documentation to support your appeal																	
<input type="checkbox"/> A copy of the denial letter received from the SXC Prior Authorization Department																	
<input type="checkbox"/> Physician letter in support of the appeal, or other supporting documentation																	
Brief explanation/reason for the appeal																	

Proprietary and Confidential