Re: Medicare D/Insurance/Medicaid Prescription Rejection

To: Director of Nursing at ______________________ Prescriber: ___________________
Resident Name: ____
Drug: ______________________Date: _______________ Rx# _____________________
Insurance Co: ____________________________ID# _________________Plan: _____________

Has been denied payment by Medicare D/Insurance/Medicaid (circle one) for the below listed reason(s):

[ ] Reason: Drug Not Covered

Resolution: These drugs are offered as alternatives by the insurance company

Signature below authorizes prescription of new Medication

____

(List Drugs)

Sig for alternative therapy (dose, route, frequency etc.): ____________________________
(Sig Required)

Prescriber signature: _______________________________ Date: _____________________

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Alternative Option if Covered Alternative not Chosen:

[ ] Facility requests Non-Covered medication to be sent and agrees to pay for Non-Covered Medication if physician denies alternative Medication.

[ ] Facility requests Medication Not to be sent, if physician denies alternative Medication, and Facility will follow with DC'd order for said Medication.

MAC Rx Pharmacy Phone: 224-220-2700 Fax: 224-220-2730

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