



# Hennepin Health

## Prescription Drug Reconsideration Request Form

**Fax to: 612-632-8815**

Hennepin Health  
Minneapolis Grain Exchange Building  
400 South Fourth Street, Suite 201  
Minneapolis, Minnesota 55415

**Please call 612-596-9914  
immediately when request is faxed**

### Recipient Information

RECIPIENT NAME		RECIPIENT ID NUMBER
CITY	STATE	DATE OF BIRTH (MM/DD/YYYY)

### Provider Information

PROVIDER NAME		NPI
CITY	STATE	PHONE NUMBER ( )
PROVIDER SIGNATURE	DATE	FAX NUMBER ( )

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

### Pharmacy Information

DISPENSING PHARMACY		NPI
CITY	STATE	PHONE NUMBER ( )

### Request Information — Provide a copy of the original prior authorization request and denial letter.

DATE OF ORIGINAL REQUEST	ORIGINALLY REQUESTED BY <input type="checkbox"/> Prescriber <input type="checkbox"/> Pharmacy	DATE OF DENIAL NOTIFICATION	IS ADDITIONAL INFORMATION BEING SUBMITTED? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Requester is encouraged to submit any additional information to support the request for appeal including, for example, clinic notes and dates of previous medication trials.

### Rationale/Medical Reason for Disagreement (attach additional documentation if needed)

FOR HENNEPIN HEALTH USE ONLY

DETERMINATION <input type="checkbox"/> Approved <input type="checkbox"/> Denied Notification	SENT TO <input type="checkbox"/> Prescriber <input type="checkbox"/> Pharmacy	DATE SENT
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