AULTCARE

Phone: 330-363-6360
Fax: 330-363-3284

Healthcare Reform Copay Waiver Request Enrollment Form

AULTRA
ADMINISTRATIVE GROUP

APATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	☐ NKDA
Date of Birth	SSN#	Weight _____ ☐ lb ☐ kg Date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address (optional)	

INSURANCE INFORMATION

Primary Insurance		Policyholder
Group #	Policy #	Phone #

Service Is: ☐ Routine/Non-Urgent ☐ Expedited/Urgent*

*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside this definition should be submitted as routine/non-urgent.

MEDICAL INFORMATION **(PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)**

Medication Name:_____ Strength:_____

Directions:_____

☐ check if requesting brand name ☐ check if continuation of therapy

What is the patient's diagnosis for the medication being requested?

ICD-10:_____

Please list the medication(s) the patient has tried and had an inadequate response to. (Please specify ALL medication/strengths tried, length of trial, and reason for discontinuation of medication)

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Please list the medication(s) the patient has contraindication or intolerance to. (Please specify ALL medication/strengths with the associated contraindication to or specific issues resulting intolerance to each medication)

Are there any supporting labs or test results? (please specify)

Quantity limit request:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

☐ Titration or loading dose purposes
☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
☐ Requested strength/dose is not commercially available
☐ Patient requires a greater quantity for the treatment of a larger surface area [topical applications only]
☐Other:

Are there any other comments, diagnosis, symptoms, medications tried and failed, and/or information the physician feels is important to this review:

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	

Physician's Signature _____ **Date** _____