To File a Formal Appeal if you have Received a Denial

Exouza Clinical Pharmacy Services
1405 S Fern St #93729
Arlington, VA 22202

FAX:1-703-991-4496

You may file an appeal with Clinical Pharmacy Services regarding the decision of your prescription request(s). You have 180 days to file your appeal in writing. The appeal can be faxed to 701-991-4496 or mailed to the address above.

If your need for care is urgent, we will respond as soon as possible, but no later than 72 hours after receiving your appeal. This is an expedited appeal. An expedited external review can occur concurrently with this internal appeal process. In all other cases, we will give you our response no later than 7 days after you file your appeal. This is a standard appeal. There is no charge to you, the member, to file an appeal.

Please fill out the Prior Authorization Appeal Request Form included in this mailing along with the following:

- Member's name
- Member's contract number
- Information to identify the claim(s) you are appealing.
- A statement explaining that you are filing an appeal and a written explanation of why you believe this case should be approved. Please submit all medical records, peer review articles, and comments for consideration that may support your appeal.

Please fax the above information including the attached Prior Authorization Appeal Request Form to Clinical Pharmacy Services at 1-703-991-4496.

EXOUZA
...powered by you!

PRIOR AUTHORIZATION APPEAL REQUEST

An appeal may be filed in the event that you wish for us to reconsider and change a decision we have made about what prescription drug benefits are covered for the member. The appeals process must be initiated within 180 days of the original denial. Standard appeal requests will be reviewed within 7 working days. You may request an expedited appeal if the member's health status is jeopardized by the standard processing time in which the appeal will be processed. Expedited appeal requests will be reviewed within 72 hours. **To make an appeal, please complete the form below and fax it to1- 703-991-4496 along with any additional supporting evidence.**

APPEAL REQUEST

Please indicate the request you are submitting:

☐ **STANDARD** – decision will be made within 7 working days

☐ **EXPEDITED** – decision will be made within 72 hours

Date of Submission: _____

PRESCRIBER INFORMATION		PATIENT INFORMATION	
Prescriber Name	Prescriber ID	Patient Name	
Prescriber ADDRESS (street, city, state, zip)		Patient Address (street, city, state, zip)	
PHONE	FAX	Patient DOB	DIAGNOSIS

If additional space is needed, please use separate sheet and attach to form.

Prior Authorization Decision in Question:

I do not agree with the determination of the Prior Authorization request. MY REASONS ARE:

Additional information for us to consider:

I certify that the information above is accurate. I understand that penalties may apply for falsified or misrepresented information.

Requester's Signature:_____ Date:_____
Requester's Name:_____ Relationship to member:_____
Requester's Address_____ Requester's phone:_____