



Patient Safety Through Innovation

Fax to: (251) 625-6502 OR (866) 478-7909
Attn: Admissions & Billing Departments

PATIENT RESPONSIBILITY REQUEST FORM
FOR A DRUG THAT HAS PRIOR AUTHORIZATION REJECT

The pharmacy has received a request for a medication and /or item(s) that are not covered by the payer source. A prior authorization must be obtained by the doctor. We have provided this information to the doctor.

In order for the pharmacy to dispense this medication and/or item(s), a signature authorizing payment is needed. By doing so, the patient is accepting charges for the medication and/or item(s) listed.

MEDICATION CAN NOT BE DISPENSED UNTIL PAYMENT OR PRIOR AUTHORIZATION HAS BEEN OBTAINED.

FACILITY: \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Last First MI

Date of Birth: \_\_\_\_\_

Payer Source: \_\_\_\_\_

Medication / Item: \_\_\_\_\_ Qty: \_\_\_\_\_ \$ \_\_\_\_\_

Covered Alternatives: \_\_\_\_\_

Please note that all payment authorizations are good for the life of the prescription unless otherwise requested.

Please complete the following information:

YES - Patient will pay for drug: Drug will be dispensed as written and billed to the patient.

NO - Patient will not pay for drug until prior authorization is received: Drug will not be dispensed until prior authorization is received.

Patient Name: \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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