WELLFLEET

Extension of Benefits

Prescription Drug Approval Request Form

MEMBER INFORMATION	
Name:	Gender (Circle One): M F
DOB:	Other Insurance:
Member ID:	

PROVIDER INFORMATION	
Name:	NPI:
Tel:	Specialty:
Fax:	Address:
Contact Person:	

PRESCRIPTION AND CLINICAL INFORMATION
1)Date Rx Written:
2)Drug Name/Strength:
3)Dosage Form:
4)Quantity:
5)Directions:
6)Diagnosis:
7)Generic Substitution Allowed?
8)Refills:
9)Additional Comments:

Please attach supporting clinical information, which should include if available:

- ✓ Copy of Prescription
- ✓ Medical Records
- ✓ Lab Reports
- ✓ Progress Notes
- ✓ Diagnostic Studies
- ✓ Referrals
- ✓ Plan of Care

Please note: Determination of approval will be made within one business day of receiving this form and all necessary information. There may be a delay if additional information is needed.

Completed form and all supporting documentation may be submitted to Wellfleet via fax or email:
Fax: 413-781-1958 Email: priorauth@wellfleetinsurance.com