Pharmacy Appeal Form

If you disagree with our decision to deny a claim or reduce pharmacy benefits, use this form to request reconsideration. You are invited and encouraged to attach any documentation that supports your appeal, such as medical records, bills and notes from doctors. For medical benefit denials or reductions, please use the Medical Appeal Form.

St Luke's™ + Health Plan

Subscriber Name:		**Patient Name** (Person that is the subject of the appeal):
Subscriber ID:		**Patient DOB:**
Patient Street Address:		**Patient Phone:**
City:		**Medication and Dose:**
State:	**Zip:**	**Provider Name:**
Preferred method of contact regarding this appeal: Phone ☐ Email ☐ Mail ☐		**Expedited/Urgent?** No ☐ Yes ☐ Expedited appeals are only available for services that have not yet been rendered.

Members over the age of 18 may either file their own appeal or formally appoint someone to represent them. To appoint someone, sign and submit a Designated Authorized Representative (DAR) form. To access this form, visit our website at www.stlukeshealthplan.org or call Pharmacy Customer Service at **833-975-1281.** A signed DAR form is not required for providers to appeal on behalf of a member.

What is the reason for the appeal?

What medication(s) has the patient tried and failed?

Consent for St. Luke's Health Plan to investigate this appeal

Signature: _____ **Date:** _____

Relationship to patient: _____

Send completed forms via mail, fax, or email:

Fax: 833-850-0171 Email: pharmbenefitmgmntsup@slhs.org
Mail: ATTN: Appeals, St. Luke's PBM, 800 Park Blvd, Boise, ID 83712
Questions? Call the Pharmacy Department at **833-975-1281**