Pharmacy Medication Review Request

Fax Cover Form **1-888-343-4232**

This is just the review request cover sheet. You need to submit additional medical information related to your review request along with this form.

Please use this form for BlueCross BlueShield of Tennessee Commercial and CoverKids members ONLY.

All fields must be filled in for us to complete the review, otherwise we'll return this form which will delay the review process.

Today's Date: ________ /________ /_______________
MM / DD / YYYY

Number of pages including cover sheet: ________

Request for Expedited Review

☐ By placing a check mark here, I certify the standard review time may seriously jeopardize the life or health of the member or member's ability to regain maximum function.

Member Information (Required)

Last Name ____

First Name ____

BlueCross Member ID: Letters ______________________ Numbers______________________

Address ______________________________________ State ______Zip ____________

Telephone Number ______________________________

Date of Birth ______ /______/_________
MM / DD / YYYY

Medication Information (Required)

Drug Name and Strength: ____

☐ Self Administered? ☐ Provider Administered?

Directions for use: ____

Quantity per 30 days: ______________________________

Date requested for approval of authorization to begin:________ / _________/____________
MM / DD / YYYY

Practitioner Information (Required)

Last Name/First Name: ______________________________________ NPI: ____________________

Office Fax No.:_________________________________ Office Phone No.: _______________________________