

For urgent or expedited requests, call 888.563.2250.  
This form may be used for non-urgent requests and faxed to 916.568.5280.



# Healthcare Reform Copay Waiver Request Form

## MEMBER INFORMATION

Member Name: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name: \_\_\_\_\_  
NPI #: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Office Phone: \_\_\_\_\_  
Office Fax: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

## MEDICATION INFORMATION

Medication Name: \_\_\_\_\_  
Strength: \_\_\_\_\_ Dosage Form: \_\_\_\_\_  
 Requesting BRAND  Continuation of therapy      Directions for Use: \_\_\_\_\_

## CLINICAL INFORMATION

What is the patient's diagnosis for the medication being requested?

ICD-10 Code(s): \_\_\_\_\_

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

*This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Western Health Advantage. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing, or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.*