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

westernhealth ADVANTAGE

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?