CSR:____________________________
Date/Time:________________________

Pharmacy Override Request

☐ Medicaid ☐ CHIP ☐ CHIP Perinate

Member Name:______________________________ **DOB:**_________________**Member ID:** _____________________

Member Phone:______________________________ **Member Zip Code:**______________________

Pharmacy:__________________________________

Pharmacy Phone:_____________________________ **Has Medication Been:** ☐ **Paid for** ☐ **Picked up**

Requested Medication(s) and Strength: ____

Description of Request:____

____

Mode of Travel: ______________________ **Departure Date:** ____________________ **Arrival Date:** __________________________

Reason for Request:____

____

***Please send form and travel itinerary, if applicable, to PCHPRxHelp@phhs.org**

Requestor: ☐ **Provider:** ____________________________________ ☐ **Member:** ____

Requestor Phone:_________________________

Primary Care Provider Name:__________________________ **Primary Care Provider Phone:**____________________________________

Reviewer:_______________________________

☐ **Approved** ☐ **Denied**

Reason for denial:____

____