

REQUEST FOR OUT OF STATE PHARMACY SERVICES



Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
DXC Technology ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

Today's Date _____

Beneficiary Name _____

Address _____

DOB _____ Medicaid ID Number _____

Date began providing services _____

Pharmacy Name _____

NPI # _____

Pharmacy Address _____

Phone Number _____ Fax Number _____

Contact Person _____

Phone Number _____

E-mail address _____

Date discharged from service _____

Reason _____

If transferred to other pharmacy, name of pharmacy _____

** Please note that this is not an authorization for payment. All policies and procedures for eligibility and pharmacy benefits must still be met.