

Please note: All information below is required to process this request. Monday – Friday: 8:00 AM to 4:30 PM Eastern
 Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | www.carefirstchpdc.com

Travel Medication Supply Prior Authorization Request Form

Patient Information				Provider Information		
Patient Name:				Provider Name:		
Member ID#:				NPI#:		Specialty:
Date of Birth:		Phone: ()		Office Phone: ()		
Street Address:				Office Fax: ()		
City:	State:	Zip:		Office Street Address:		
Drug Allergies:				City:	State:	Zip:
Medication Supply Requested						
	Medication	Quantity	Number of Days			
a.						
b.						
c.						
d.						
e.						
f.						
g.						



This program is funded in part by the Government
 of the District of Columbia Department of Health Care Finance

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By signing this form, I attest to the fact the beneficiary indicated above is in regular medical care, has scheduled medical appointment with his/her doctor after returning to the District.

Case Manager Name: _____ Signature _____
Date: _____ Agency: _____
Phone Number: _____

- The prior authorization request should be submitted 7 days prior to intended day of travel
- The prior authorization request form can be filled out by beneficiary's case manager in consultation with beneficiary's doctor.
- The following documents should accompany this prior authorization form:
 - A copy of prescription for the medication requested
 - A copy of the confirmed round trip travel itinerary
 - Documents from authority indicating purposes and dates of travel which should matche the dates provided on itinerary
 - A letter from the provider to justify the request
- A maximum of one 90 day supply will be authorized per year. However, any exceptional requests for unforeseen circumstances will be reviewed case by case.



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