



Maricopa County Pharmacy Program Appeal Form

[Please Print Legibly]

EMPLOYEE INFORMATION

Employee's Name _____

Pharmacy Plan ID # _____

Mailing Address _____

City, State, Zip Code _____

Day Time Phone # _____ Evening Phone # _____

Email Address _____

PATIENT INFORMATION

Name _____ Date of Birth _____

Relationship to Employee _____

PRESCRIBING PHYSICIAN INFORMATION

Name _____

Address _____

City, State, ZIP _____

Phone # _____ Fax # _____

PHARMACY INFORMATION

Pharmacy Name _____ Phone # _____

Medication Name _____ Prescription # _____

1. Please tell us what you are appealing. (Please use the back of this form if more space is needed to answer these questions.)

2. Please tell us what you would expect the results of this appeal to be.

3. Please explain why you think your appeal should be approved. Provide substantiating medical documentation, as appropriate.

4. Please attach a copy of your denial letter with this completed form.

Signature of Insured _____

Date _____

Send this completed form to:

Employee Benefits Division

301 W. Jefferson St., Suite 3200

Phoenix AZ, 85003

602-506-1010 / Fax: 602-506-2354

benefitsservice@mail.maricopa.gov

Please make a copy of this completed form for your personal records.