Prior Authorization Form
URGENT

Use this form to authorize an eligible recipient to receive medications for any reason outside their normal parameters under the Prescription Drug Plan.
Complete & Fax back to 229-225-9945

Date of Request:___

Cardholder Information	
Member Name	DOB
Member Identification Number	Group Number
Patient name	**Relationship** Self Spouse Child

Provider Information	
Medication/Dose Requested:	
In order to complete our review and make an appropriate determination, the following information will Be necessary:	
Diagnosis:	Physician Contact: Physician Phone #: Physician Fax #:
Previous Medication Treatment History	
Other relevant patient information	

Taylor Benefit Resource Authorizing Agent Information	
This communication is to direct Taylor Benefit Resource to permit our eligible recipient, to receive the listed medication or therapeutic coverage through the Prescription Drug Plan. **Please Do Not Write Below This Line**.	
Authorizing agent Signature:	
Date:	