ProCare Rx

Quantity Limit
Medical Necessity Form

The following documentation is REQUIRED in consideration of approval for the prescribed quantity. Incomplete forms will be returned for additional information.

A. Member Information				
Patient Name: Last:	First:		Middle:	
Date of Birth:	Member ID #:		Group #:	
Address:	City:	State:	Zip:	Phone #:

B. Clinical Information *(Please provide all requested information – incomplete forms will be returned for additional information.)*	
Medication Name:	Medication Strength:
Prescribed Quantity Per Month:	Dosing Schedule:
Patient Diagnosis:	Anticipated Length of Treatment:
Previous treatment options that were utilized:	
Detailed explanation of therapy failure or adverse effect experienced during previous course of treatment:	
Medical history relevant to this diagnosis:	

C. Physician Information		
Physician Name:	Specialty:	Physician NPI #:
Phone #:	Fax #:	
Physician Signature:	Date:	

Please fax the completed form to ProCare Rx, ATTN: Clinical Department at (248) 948-9904.

If you should have any questions regarding the reimbursement process, please call ProCare Rx Clinical Department at (800) 311-3446.

ProCare Rx
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Phone: (800) 311-3446 | Fax: (248) 948-9904 | Website: www.procarerx.com