fridayhealthplans.com
844-521-7900

Member Information		
Member Name:	**DOB:**	**Member ID:**
Member Address:	**Member Phone #:**	
Provider Information		
Provider and NPI:	**Address:**	
Phone:	**Fax:**	
Medication/Dispensing Information		
Drug Name:		
Strength:	**Quantity:**	
Duration:	**Diagnosis code:**	
Administration Location*(patients home, office, infusion center, ect.):*		
☐ **Continuation of treatment**	☐ **Brand Name being requested**	
☐ **Administered by Member**	☐ **Administered by someone other than member(specify)**	
If the member has tried and failed any treatments, please provide in detail treatment regimens that have been tried and failed.		
Briefly describe why medications on the formulary are not alternative options to the non-formulary medication. (attach additional information such as a physician's letter, medical records, or other documents to support your claim):		

Please refer to fridayhealthplans.com for our formulary medications. Failure to provide clinical documentation/complete this form in entirety may result in the delay or denial of your request.

Send this form, your denial notice, and any supporting documentation to:

Friday Health Plans ATTN: Appeals and Grievances
700 Main St.
Alamosa, CO 81101
Phone: 1-800-4758466 Fax: 1-844280-1794
Email: appeals@fridayhealthplans.com

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.