CASH WAIVER FORM

DATE: ____/____/____

Submission of this form to the Bureau for Medical Services is voluntary and is not required by any BMS policy or regulation. Payment for quantities of medications dispensed and covered by BMS pharmacy services policy is not jeopardized by submission of this form.

Member Name: (print) __________________________________________________

Member ID# ___________________________________________________________

Pharmacy Name ___________________________ Pharmacy NPI#_________________________

Medication Needing PA ______________________________________________________

Prescriber___________________________________ Prescriber NPI#________________________

Total Quantity Prescribed_____________ Days’ Supply___________________

Quantity for Cash Payment ___________ Amount Paid___________________

Some medications or quantities of medication require Prior authorization by the Bureau for Medical Services. This means additional information is needed from the prescriber. If the request meets the BMS Pharmacy Program criteria, the Bureau will approve the request. The member will be charged only the Medicaid co-pay for the medication.

By signing below, you indicate that you understand the following:

• You have been informed that this medication requires Prior Authorization by the Bureau.
• You have chosen not to request Prior Authorization through the pharmacy or the prescriber.
• In order to receive this medication without the Bureau’s Prior Authorization, you will have to pay the usual and customary price of this medication.

Member Signature: _________________________________________________________________

Pharmacy Representative Signature ____________________________________________________

Please fax the completed form to the Bureau for Medical Services at 1-304-558-1542.

Rev: 8/01/2013