



**RAMSELL**  
PUBLIC HEALTH RX

**CALIFORNIA**

**PROVIDER SERVICES: (888) 311 – 7632**  
**FAX: (800) 848 -4241 or 510-587-2799**

**VERSION 7 - AUTHORIZATION FORM**

*PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS!*

**PHARMACY INFORMATION**

**NABP:** \_\_\_\_\_ **Sent By:** \_\_\_\_\_  
**STAMP or WRITE Pharmacy Name, Phone & Fax:**

**CLIENT INFORMATION**  
(Print Clearly)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

I.D. : \_\_\_\_\_

PHONE: (    )    \_\_\_\_\_

FAX: (    )    \_\_\_\_\_

D.O.B.    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MUST CHECK ALL THAT APPLY!**

Medi-Cal SOC

Date Verified:    \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Amount: \$ \_\_\_\_\_

Eligibility Expiration

Vacation Supply

ADAP Share of Cost

ADAP Dispensing Restriction

(Provide proof of code 1 in the notes/explanation section)

Early Refill (Provide explanation)

DAW override \_\_\_\_\_

Client Not Enrolled into a Medicare Part D Plan

Medicare Part D Plan Billing

\_\_\_\_\_ Plan Name

Private Insurance Billing

\_\_\_\_\_ Plan Name

POS Printback Copy must accompany this request (DO NOT AFFIX LABELS TO PA FORM)

**NOTES/EXPLANATION:**

*Note: All claims over 90 days will be denied.*

	Co-Pay or Cash Price	Requested QTY	Days Supply	Requested PA Date
RX#1	NDC : _____ \$: _____	_____	_____	_____
RX#2	NDC : _____ \$: _____	_____	_____	_____
RX#3	NDC : _____ \$: _____	_____	_____	_____
RX#4	NDC : _____ \$: _____	_____	_____	_____
RX#5	NDC : _____ \$: _____	_____	_____	_____
RX#6	NDC : _____ \$: _____	_____	_____	_____
RX#7	NDC : _____ \$: _____	_____	_____	_____
RX#8	NDC : _____ \$: _____	_____	_____	_____
RX#9	NDC : _____ \$: _____	_____	_____	_____

**Check this box if you require manual billing for these prescriptions.** (For pharmacy providers who can not split bill or prescriptions over 60 days old.)