MEDICAL PARK Rx
Specialty Services

Specialty Care ***Close to Home***™

To Whom it May Concern,

I hereby authorize Medical Park Pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services, and patient assistance program coordination for prescription orders it receives for my patients. I will provide Medical Park Pharmacy with all clinical information that is necessary in order to obtain prior authorization. I understand that prior authorization approval and insurance benefits will be determined by the payor based upon each patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things, and that participation in this program is not a guarantee of prior authorization or of payment. Upon request, Medical Park Pharmacy will provide me with a copy of the information that was submitted for prior authorization. This authorization form will be active for 1 year or until I retire or leave the practice, whichever is sooner. When the prior authorization expires, Medical Park Pharmacy will contact my office to ensure that the patient is to continue treatment of prescribed medication and, if so, will send me a new authorization form for my signature.

Signature:_____

Date:_____

Prescriber's Name:_____

Contact Phone:_____

NPI#:_____