

Rx Claim Exception Form – GLAS



The following form should be completed if the Plan has decided to make an exception for the plan participant to obtain maintenance medications at non-Gundersen Pharmacy locations. This form should only be completed and submitted by a representative of the Plan who has been authorized to make exceptions on behalf of the Plan Sponsor. This form will not be accepted by persons who have not been authorized by the Plan to submit. Once completed, this form should be emailed to the following email address for review and signature, if approved. QuartzLargeGroupService@QuartzBenefits.com

Type of Request: Urgent (prescription(s) required within 24-hours)
 Standard (request processed within 48 hours upon receipt)

To determine if you and/or your dependent(s) covered under the Plan are eligible for an exception you must meet one or more of the criteria outlined below. Using the check box, please indicate which of the criteria apply.

- Tried the Gunder 90 mail-order program, and the maintenance medications can't be filled for specific reasons (i.e. shipping difficulties)
- Live more than 50 miles from a Gundersen Pharmacy location or partner pharmacy location (partner pharmacies: NuCara Pharmacy (West Union, IA), Scott Pharmacy (Fayette, IA), Peterson Pharmacy (Hillsboro, WI), Boscobel Pharmacy (Boscobel, WI), Nightingale Drug (Postville, IA), Blair Pharmacy (Blair, WI), and Colby Hometown Pharmacy (Whitehall, WI))
- Live where the medication(s) cannot be delivered (outside of WI, IA, IL, or MN). Not applicable if you're on the PPO plan
- Gundersen Pharmacy does not accept your secondary insurance
- Live in a long-term care or behavioral health facility that does not allow prescriptions from other sources
- Receive controlled substances and live more than 50 miles from a Gundersen Pharmacy location or partner pharmacy location

Request Date: ____ / ____ / ____	Participant Date of Birth: ____ / ____ / ____
Participant First Name: _____	Participant Last Name: _____
Mailing Address: _____	State: _____ Zip: _____
Participant ID: _____	Date Range for Exception: ____ / ____ - ____ / ____
Phone Number: ____ (____) _____	Authorized to leave voicemail: <input type="checkbox"/> Yes <input type="checkbox"/> No

I agree that the answers are, to the best of my knowledge and ability, complete and true. I understand that any material misstatement or omission may result in the denial of this request.

Participant Signature: _____ Date: ____ / ____ / ____

Note: Exception requests will only be granted for the plan year in which the exception was originally requested. Each plan participant covered under the policy will need a separate exception request form.

OFFICE USE ONLY

I, _____ the undersigning party, represent to Quartz that I have the authority to act on behalf of the Plan Sponsor of the self-funded health plan Gundersen Lutheran Administrative Services (GLAS), and that I have the authority under the Plan to direct Quartz to process the above-described pharmacy service as eligible for coverage under the Plan. Therefore, on behalf of the Plan, I direct Quartz to process the prescription(s) incurred by the above-named plan participant, as eligible for coverage under the Plan.

Signature: _____ Date: ____ / ____ / ____

Printed Name: _____ Title: _____

Exception Request Granted: Yes No

If no, the reason for denial: _____