



PART D OVERRIDE REQUEST

Client Name: _____
 DOB: _____ Medicaid Number: _____
 Practitioner Name: _____ Provider Number: _____
 Office Phone Number: _____ Office Fax Number: _____
 Submitted Eligibility Transaction to NDC Health: Yes No
 Did the client choose a Prescription Drug Plan for Medicare Part D? Yes No
 Date: _____ Additional Comments: _____

Office Use Only

| | | |
|--------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> DPAP | <input type="checkbox"/> CRDP | <input type="checkbox"/> MEDICAID |
| START DATE: _____ | END DATE: _____ | |
| <input type="checkbox"/> 6112 | | |
| UNITS: _____ | | |
| <input type="checkbox"/> OTHER | <input type="checkbox"/> OTHER | |
| DRUG CODE: _____ | DRUG CODE: _____ | |
| UNITS: _____ | UNITS: _____ | |
| <input type="checkbox"/> OTHER | <input type="checkbox"/> OTHER | |
| DRUG CODE: _____ | DRUG CODE: _____ | |
| UNITS: _____ | UNITS: _____ | |

PLEASE COMPLETE AND SUBMIT REQUEST FORM AT WWW.DMAP.STATE.DE.US
 OR
 FAX COMPLETED FORM TO 302-454-0224