Commonwealth of Massachusetts Executive Office of Health and Human Services

[www.mass.gov/masshealth](http://www.mass.gov/masshealth)

**Pharmacy 90-Day Waiver Form**

Use this form to request a 90-day waiver for a MassHealth or Health Safety Net claim for one of the reasons indicated in the Explanation below. All fields must be completed to process the request.

**Pharmacy Information**

(Required to receive approval notification)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Pharmacy name | Provider number | Fax Number | Location code |

**MassHealth Member Information/Health Safety Net (HSN) Patient Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last name | First name | Date of Birth (mmddyyyy) | GenderMo Fo | Member ID |
| Address | City | State | ZIP |

**Claim Information**

|  |  |  |
| --- | --- | --- |
| Manufacturer | Item | Pkg. |
|  |  |  |  |  |  |  |  |  |  |  |
| Prescriber’s NPI | Date written | Date filled |

|  |  |  |
| --- | --- | --- |
| Drug name | Quantity | Days’ Supply |
| Prescription # | Usual Charge | Other paid amount | Prior authorization # |

**1**

**Claim Information**

|  |  |  |
| --- | --- | --- |
| Manufacturer | Item | Pkg. |
|  |  |  |  |  |  |  |  |  |  |  |
| Prescriber’s NPI | Date written | Date filled |

|  |  |  |
| --- | --- | --- |
| Drug name | Quantity | Days’ Supply |
| Prescription # | Usual Charge | Other paid amount | Prior authorization # |

**2**

**Claim Information**

|  |  |  |
| --- | --- | --- |
| Manufacturer | Item | Pkg. |
|  |  |  |  |  |  |  |  |  |  |  |
| Prescriber’s NPI | Date written | Date filled |

|  |  |  |
| --- | --- | --- |
| Drug name | Quantity | Days’ Supply |
| Prescription # | Usual Charge | Other paid amount | Prior authorization # |

**3**

**Claim Information**

|  |  |  |
| --- | --- | --- |
| Manufacturer | Item | Pkg. |
|  |  |  |  |  |  |  |  |  |  |  |
| Prescriber’s NPI | Date written | Date filled |

|  |  |  |
| --- | --- | --- |
| Drug name | Quantity | Days’ Supply |
| Prescription # | Usual Charge | Other paid amount | Prior authorization # |

**4**

**Explanation:** Please indicate the reason for the 90-day waiver request below.

* Rebilling a previously denied claim that was filed on time. Attach remittance advice.
* Retroactive member enrollment. Attach proof.
* Retroactive provider enrollment. Attach proof.

**Please fax the completed form to Conduent at (866) 556-9315.**

Note for MassHealth members’ claims only: Submit claims that are older than 12 months (18 months for third party liability claims) directly to: MassHealth Final Deadline Appeals, 100 Hancock Street, Quincy, MA 02171 — Tel: (617) 847-3115

PH-90 (Rev. 05/18)