Commonwealth of Massachusetts
Executive Office of Health and Human Services
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)	Gender M☐ F☐	Member ID
Address		City	State	ZIP

Claim Information

1

Manufacturer	Item	Pkg.	Drug name		Quantity	Days' Supply
Prescriber's NPI	Date written	Date filled	Prescription #	Usual Charge	Other paid amount	Prior authorization #

Claim Information

2

Manufacturer	Item	Pkg.	Drug name		Quantity	Days' Supply
Prescriber's NPI	Date written	Date filled	Prescription #	Usual Charge	Other paid amount	Prior authorization #

Claim Information

3

Manufacturer	Item	Pkg.	Drug name		Quantity	Days' Supply
Prescriber's NPI	Date written	Date filled	Prescription #	Usual Charge	Other paid amount	Prior authorization #

Claim Information

4

Manufacturer	Item	Pkg.	Drug name		Quantity	Days' Supply
Prescriber's NPI	Date written	Date filled	Prescription #	Usual Charge	Other paid amount	Prior authorization #

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: PBME@mass.gov