ITASCA MEDICAL CARE
Override Request Form

Date: _____

Patient Name: _____ **DOB:** _____

IMCare ID Number: _____

Physical Name (PRINT): _____

Clinic: _____

Provider Phone Number: _____

Person Submitting Form on behalf of provider:

_____

Phone Number: _____

OFFICE USE ONLY

☐ **Override entered**
☐ **No Override needed**

IMCare Initials: _____

Date: _____

PLEASE PRINT DRUG NAME

Medication/Strength:	☐ **Provider approves early refill of controlled substance**
Dosing Schedule:	***Date of Last provider visit:***

PLEASE CHECK AND EXPLAIN BELOW AS APPROPRIATE:

Enrollee Diagnosis: _____ ICD-10 code: _____

Specify reason for override request:

☐ Dose change

☐ Partial fill

☐ Lost, explanation _____

☐ Stolen, please include police report

☐ Vacation

☐ Other, specify reason for override request: _____

_____

FAX TO: 218-327-5545

Revised: 04/24/2020