PRICING RESEARCH REQUEST FORM

Date _____

Pharmacy Information

Pharmacy Name:	
NCPDP#:	**NPI#:**
Contact Name:	**Email:**
Phone Number:	**Fax Number:**

Claim Information

Rx Number:	**Fill Date:**	
Amount Submitted:	**Dispensing Fee:**	**Total Paid:**
Member Name:	**Member Id:**	
Drug Name & Strength:		
NDC Number:		
Qty Dispensed:	**Days' Supply:**	**U&C Price:**

Prescription Copy, and Invoice or Proof of Acquisition Cost must accompany this request. Incomplete requests will not be processed. Send completed form, along with required supporting documentation to Fax: 1-866-912-2830 and/or Email: mac.appeals@pharmpix.com for any questions call: 787-522-5252 ext.184. As stated in the Provider Manual, requests will be reviewed as soon as possible, but no later than 10 business days from date in which request was received by PharmPix. Only prescriptions with 90 days of process in our system will be considerate for evaluation for cost revision.

For PharmPix use:

Date received _____ Date reviewed _____ By (initials) _____

Approved/Denied _____ Notification Date _____ By (initials) _____