PRICING RESEARCH REQUEST FORM

Date _____

Pharmacy Information

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

Claim Information

Rx Number:	**Date of Service:**	
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 (less than 6 months of the purchase) must accompany this request. Incomplete requests will not be processed. Send the 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 the date on which the request was received by PharmPix. Only prescriptions with 90 days of process in our system will be considered for evaluation for cost revision.

For PharmPix use:

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