PHARMACY ADJUSTMENT REQUEST

MAIL TO :
HP ENTERPRISE SERVICES
POST OFFICE BOX 300009
RALEIGH, NORTH CAROLINA 27622

ATTN: ADJUSTMENT UNIT

RECIPIENT MEDICAID NUMBER

PHARMACY NAME AND PROVIDER NUMBER

RECIPIENT NAME
LAST FIRST MIDDLE

PLEASE PRINT OR TYPE (BLACK OR DARK BLUE ONLY) **LIST INFORMATION AS GIVEN ON RA**

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Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) PAID AMOUNT

1

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) PAID AMOUNT

2

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) PAID AMOUNT

3

Rx NUMBER	DRUG NAME-STRENGTH-DOSAGE-MFG	NDC	QUANTITY	BILLED AMOUNT

DATE FILLED MO DAY YR	CLAIM NUMBER	DENIAL EOB	INS PAID

ADJUSTMENT REASON (BRIEFLY DESCRIBE REASON FOR ADJUSTMENT) PAID AMOUNT

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment will be from Federal and State funds, and that any false claims, statements, or documents, or concealment, of a material fact, may be prosecuted under applicable Federal or State laws."

X_____
CLAIMANT SIGNATURE DATE

IMPORTANT: THIS FORM WILL BE RETURNED IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING IS NOT PRESENT.

FORM NO. 372-200 (REVISED 5-2010)