

STATE MAXIMUM ALLOWABLE COST – REQUEST FOR MEDICAID REIMBURSEMENT REVIEW

Pharmacy providers should use this form to report changes in drug pricing.

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) MUST BE COMPLETED FOR PROPER SUBMISSION OF THIS FORM

Pharmacy Provider Information

Pharmacy Name _____ *

NPI _____ *

City _____ State _____ *

Phone _____ Email _____ *

Drug Information: *Please enter information for*

one (1) drug per submitted form Drug Name _____

National Drug Code (NDC) _____ * (e.g., 12345-6789-10)

Provider Cost Information

Cost Per Package	\$ _____ *	Is this a recent change in reimbursement?	Y / N *
Package Size	_____ *	Has there been a recent increase in acquisition cost?	Y / N *
Date of Purchase	_____ *	Are there availability issues?	Y / N *
		Are you able to purchase alternate NDCs?	Y / N *

Claim Information

Dispense Date _____

Quantity Dispensed _____

Dispensing Fee \$ _____

Total Reimbursement for claim
(including disp. fee) \$ _____

Medicaid co-pay due from recipient \$ _____

Comments:

Please print and fax this form to 317-571-8481 (attention: Pharmacy Unit) or e-mail this form to ncpharmacy@mslc.com

Be sure to include copies of your purchase records that illustrate your costs.

Once complete information is received, we will evaluate your inquiry and respond within 24 hours. For questions or to check the status of an inquiry, please contact us by e-mail at ncpharmacy@mslc.com or by phone at **800-591-1183**.

Person Submitting this Request _____

