AVERAGE ACQUISITION COST PROGRAM – REQUEST FOR MEDICAID REIMBURSEMENT REVIEW

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

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

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 copharmacy@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 **copharmacy@mslc.com** or by phone at **800-591-1183**.

Person Submitting this Request