ProCare Rx

Generic Pricing (MAC) Appeal Form

Please complete this form and email to reimbursement@procarerx.com

Date: _____

A. Pharmacy Information		
Pharmacy Name:	Pharmacy NCPDP/NPI:	
Contact Name:	Phone #:	Fax #:

B. Member Information	
Rx #:	Member ID::

C. Claim Information			
Claim Reference #:	BIN:	NDC:	Fill date:
Qty Dispensed:	Drug Name:		Invoice Price:
Additional Information:			

Complete form and email to reimbursement@procarerx.com

- All fields must be completed when submitting the form.
- *Incomplete forms will not be accepted.*
- Completed appeals must be sent within 60 days of actual claim fill date, or in accordance with state law.
- Duplicate claims will not be reviewed.
- Review of any individual claim reference number is final and will not be reviewed again.
- Reviews and final decisions shall be determined and conveyed at the sole discretion of ProCare Rx, except as required by law, where applicable.