MAC Appeal Form

All forms MUST be typed and NOT handwritten. Handwritten forms will NOT be reviewed.
All fields must be filled in. Incomplete forms will NOT be reviewed.
Invoice is REQUIRED. Forms faxed in without an invoice will NOT be reviewed.
Multiple transactions will NOT be accepted on one form, unless state regulations require otherwise.Unless different timeline required by state regulations, appeals older than 14 days from date of service will NOT be accepted. NDC in question must be the same as NDC on invoice submitted.

Complete the form and fax along with invoice to 409-924-7825.

For additional questions, please e-mail macappeal@scriptcare.com

Date Requested:_____

Pharmacy Information

NABP :
NPI :
Pharmacy Name :
Contact Name :
Contact Email and/or Fax Number :

Patient Information

Patient First and Last Name :
Date of Birth :
ID Number :
Group Number :
Claim Authorization Number :

Prescription Information

BIN :
PCN :
Rx Number :
Date of Service :
Drug Name and Strength :
NDC:
Quantity :

Pricing Information

U & C Price :
Pharmacy Acquisition Cost :
Patient's Co-pay Amount :
Dispensing Fee :
Amount Paid by Third Party :

Notes

DisclosedRx
The Fiduciary and Fully Disclosed PBM®