



Pharmacy Appeal & Grievance Form

- All fields are required. Incomplete forms will not be accepted.
- Reimbursement appeals must be submitted within 30 days of claim fill date or timeframe as required by law.
- Send completed form by email to Pharmacyrelations@prescriptive.com

Provider Information

Pharmacy/Provider NCPDP ID:	<input type="text"/>	Pharmacy Name:	<input type="text"/>
Pharmacy Fax Number:	<input type="text"/>	Pharmacy Phone Number:	<input type="text"/>
Pharmacy Email:	<input type="text"/>	Pharmacy State:	<input type="text"/>

Claim Information (if applicable)

BIN:	<input type="text"/>	PCN:	<input type="text"/>	Group:	<input type="text"/>
Drug Name:	<input type="text"/>	NDC:	<input type="text"/>		
RX Number:	<input type="text"/>	Fill Date:	<input type="text"/>		

Accepted Documentation:

- Photocopy of the original prescriber-generated prescription (front and back)
- Signature Logs or proof of delivery
- Prescriber-generated documentation
- Compound prescription logs (if applicable)
- Vaccine administration record (if applicable)

Please provide an explanation of the issue: