PRESCRYPTIVE HEALTH, INC.
TENNESSEE REIMBURSEMENT APPEAL PROCESS

Submit this Certification and the Tennessee Standard Reimbursement Appeal Form to: Prescryptive Health Pharmacy Relations at pharmacyrelations@prescryptive.com.

Initial Appeal Process: The initial appeal process is available for all prescription drugs or devices in Tennessee for which a pharmacy claims that the payment it received was less than its actual cost.

1. An initial appeal shall be submitted for a drug or device within seven (7) days of processing.
2. The Pharmacy must complete and submit the attached Tennessee Standard Reimbursement Appeal Form along with any supporting documentation .
3. The Pharmacy shall sign below certifying that the pharmacy has provided Prescryptive Health with all invoices or other records demonstrating the pharmacy's actual cost for the drug or device at issue, including all discounts, price concessions, rebates, or other reductions received as of the date the pharmacy filed its initial appeal.
4. The Pharmacy shall provide the majority wholesaler or manufacturer contact information, including name, phone number, and email address, if applicable.
5. Upon receipt of a complete initial appeal, Prescryptive shall make a determination within seven (7) business days.
6. Prescryptive shall provide notice to a pharmacy within five (5) business days of an incomplete appeal and include the information needed to complete the appeal.
7. The pharmacy shall be given five (5) business days to fulfill the request.
8. If a pharmacy provides the requested information, Prescryptive shall make a determination within seven (7) business days from the date of receipt.
9. If Prescryptive fails to meet the timing and notice requirements, the pharmacy's initial appeal shall be upheld. If a pharmacy fails to meet the timing requirements under T.C.A. § 56-7-3206(c)(2)(B)(ii) and this rule, Prescyptive shall deny the initial appeal pursuant to T.C.A. § 56-7-3206(c)(4).

Questions? Email: pharmacyrelations@prescryptive.com or Phone: 512-851-1853

Certification:

I certify that I have provided Prescryptive Health with all invoices or other records demonstrating the pharmacy's actual cost for the drug, medical product, or device at issue, which takes into account all discounts, price concessions, rebates, or other reductions received as of the date of this initial appeal.

Signature: _____ Pharmacy Legal Name:_____

Name: _____ Pharmacy DBA Name: _____

Title: _____ NCPDP: _____

Date: _____

TN Department of Commerce & Insurance

STANDARD PHARMACY REIMBURSMENT APPEAL FORM

Pursuant to Tenn. Code Ann. § 56-7-3206(c)(2)(D)

APPELLANT INFORMATION

First Name

Last Name

Phone

E-mail

Appellant Name if Different from Pharmacy

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Email Address

Pharmacy National Council for Prescription Drug Programs (NCPDP) Number

Pharmacy Address Line 1

Pharmacy Address Line 2

City

State

Zip

Pharmacy Phone Number

PHARMACY BENEFITS MANAGER (PBM) INFORMATION

Name of PBM or Health Insurance Company

PBM Claim Number

CONSUMER'S CLAIM INFORMATION

Bin Number

Processor Control Number

Group

Prescription Number

First Name of Insured

Last Name of Insured

Insurance ID Number

Drug or Device Name

Fill Date

Quantity Dispensed

Drug or Device Manufacturer

Reimbursement Amount

Actual Cost

Name of Wholesaler or Manufacturer if not obtained from Wholesaler

National Drug Code or Unique Device Identifier

Pharmacy's Point of Contact at Wholesaler or Manufacturer if not obtained from Wholesaler

ATTACHMENT PAGE FOR EXHIBITS TO SUPPORT ACTUAL COST