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@prescryptive.com

Provider Information

Pharmacy/Provider NCPDP ID: Pharmacy Name:

Pharmacy Fax Number: Pharmacy Phone Number:

Pharmacy Email: Pharmacy State:

Claim Information (if applicable)

BIN: PCN: Group:

Drug Name: NDC:

RX Number: Fill Date:

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: