catamaran

VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2070

Provider Pricing Appeal Form

Date :

Please complete this form and fax to 802-871-3183
Attn: Michelle Sirois, Catamaran

Provider Information: (* Indicates Required Field)

Pharmacy/Provider Name * :

Provider NCPDP ID * :

Provider NPI ID * :

Contact Name * :

Phone Number*:

Fax Number * :

Email * :

Member Information:

Member ID * :

Date of Birth * :

Last Name * :

MI:

First Name * :

Claim Information:

Rx Number * :

Date of Claim * :

NDC * :

Qty Dispensed * :

☐ Brand ☐ Generic

Product Name * :

Product Strength * :

Dosage Form * :

Payment Received on Claim * :

Purchase Price of Claim * :

Comments :

Please attach the invoice of the product being disputed when submitting this form.

This Section is for Catamaran Use Only

Claim paid off ☐ MAC ☐ FUL MAC Inquiry Sent Date

DVHA would like to override FUL ☐ Yes ☐ NO

FUL override request sent Date

Clear Form

Print