

**AVERAGE ACQUISITION COST PROGRAM – REQUEST FOR MEDICAID REIMBURSEMENT REVIEW**

Pharmacy providers should use this form to report changes in drug pricing.

**NOTE: ALL FIELDS MARKED WITH AN ASTERISK (\*) MUST BE COMPLETED FOR PROPER SUBMISSION OF THIS FORM**

**Pharmacy Provider Information**

Pharmacy Name				*
NPI		*		
City		*	State	
Phone		*	Email	

**Drug Information:** *Please enter information for one (1) drug per submitted form*

Drug Name						
National Drug Code (NDC)		-		-	*	(e.g., 12345-6789-10)

**Provider Cost Information**

Cost Per Package	\$	*	Is this a recent change in reimbursement?	Y / N	*
Package Size		*	Has there been a recent increase in acquisition cost?	Y / N	*
Date of Purchase		*	Are there availability issues?	Y / N	*
			Are you able to purchase alternate NDCs?	Y / N	*

**Claim Information**

Dispense Date		Comments:
Quantity Dispensed		
Dispensing Fee	\$	
Total Reimbursement for claim (including disp. fee)	\$	
Medicaid co-pay due from recipient	\$	

**Please print and fax this form to 317-571-8481 (attention: Pharmacy Unit) or e-mail this form to [copharmacy@mslc.com](mailto:copharmacy@mslc.com)**

**Be sure to include copies of your purchase records that illustrate your costs.**

Once complete information is received, we will evaluate your inquiry and respond within 24 hours. For questions or to check the status of an inquiry, please contact us by e-mail at [copharmacy@mslc.com](mailto:copharmacy@mslc.com) or by phone at **800-591-1183**.

**Person Submitting this Request**

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