



Request for Reconsideration Pharmacy Form

Do not use this form to rebill claims or request routine adjustments. Use this form only after all routine processing procedures have been exhausted and the adverse action is the result of circumstances beyond the provider's control.

Resubmissions should not be sent on paper, even if the claim is over one year old or out of timely filing.

If claim filing requirements are not met because of circumstances beyond the control of the pharmacy, the pharmacy may contact Prime Therapeutics State Government Solutions, LLC, the Pharmacy Benefit Management System (PBMS) vendor, to submit this form along with applicable documentation. Prime Therapeutics State Government Solutions, LLC will forward the request to the Department for review.

Provider Request

Provider Name: _____

Street Address: _____

City, State, ZIP Code: _____

Billing Provider NPI: _____

Individual to Contact: _____

Provider Telephone Number: _____

Member State ID: _____ **Date of Service:** _____

Authorization Number (if requesting an adjustment to a paid claim): _____

Reason for Reconsideration Request:

Provider Signature: _____

Prime Therapeutics State Government Solutions, LLC
Attn: GV - 4102
P.O. Box 64811
St. Paul, MN 55164-0811

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