

**Arkansas Medicaid
Price Research Request Form**



Fax this form to: 1-800-424-7976 OR

Email securely to: mrarkansaspricinginquiries@magellanhealth.com

Please note that this form is for pricing issues outside of NADAC published pricing. Please continue to notify Myers and Stauffer at info@mslcrps.com for NADAC pricing issues.

By submitting this form, I am requesting that the Arkansas Medicaid Pharmacy Staff research the reimbursement rate of the drug listed on this form (that has been submitted for payment) and respond with the outcome of this request based on the information I have provided below.

Date of Request: _____

PROVIDER INFORMATION

Provider Name: _____

Contact Name: _____

Phone Number: _____ Fax Number: _____

Medicaid Provider ID #: _____

DRUG INFORMATION

Drug Name: _____ NDC Package Size: _____

Drug Strength: _____ NDC Number: _____

Recipient ID #: _____ Rx Number: _____

Provider Acquisition Cost for NDC Package Size: _____

Wholesaler Name: _____ Quantity Dispensed: _____

Date of Service: _____

COMMENTS

STAFF USE ONLY – DO NOT MARK IN THIS AREA

Response Date: _____

Response:

The requester may be contacted to provide a copy of the invoice related to the NDC in question.