OPTUMRx

Date:

Pricing Appeal Form

Appeals must be submitted within 30 days of the claim fill date

Please complete the form and fax to 1-888-292-4814

All fields are required - Incomplete forms will not be reviewed

Provider Information:

Pharmacy/Provider Name:

Pharmacy/Provider NCPDP ID:

Pharmacy/Provider NPI:

Contact Name:

Phone Number:

Fax Number:

E-mail:

Member Information:

Last Name:

First Name:

Member ID:

Middle Initial:

Rx Number:

Date of Birth:

Claim Information:

Claim Authorization Number:

☐ Brand ☐ Generic

BIN:

PCN:

Submitted Group:

NDC:

Claim Fill Date:

Qty Dispensed:

Product Name:

Invoice Price:

Product Strength:

Drug Form:

Comments:

MUST submit invoice showing NDC of the claim being disputed with this form