

Pharmacy Appeal Form

Instructions

Complete a separate form for each prescription number that you're appealing and email or fax to pharmacynetwork@thepharmaforce.com or 866-825-0007.

- Appeals are only accepted during the appeal phase of the audit.
- All appeals must be received within forty-five (45) days of the Preliminary Results letter.

Prescription Information

Prescription number _____ Medication Name _____

Dates of dispensing being appeal _____

Initial Audit Finding Listed on Preliminary Results Letter

- | | | |
|--|---|--|
| <input type="checkbox"/> Invalid Day Supply | <input type="checkbox"/> Quantity Billing Error | <input type="checkbox"/> Missing Hard Copy |
| <input type="checkbox"/> Quantity Over-Dispensed | <input type="checkbox"/> Invalid DAW | <input type="checkbox"/> Missing Signature Log |
| <input type="checkbox"/> Use as Directed | <input type="checkbox"/> Compound Billing Error | <input type="checkbox"/> Other _____ |

Reason for Appeal

- Documentation enclosed supports manner of dispensing
- Initial audit finding does not match pharmacy records
- Other _____

Written Statement

Explain the nature of the appeal request, including any circumstances that contributed to the manner of dispensing for this prescription. If documentation that was not provided at the time of the audit is being submitted, please explain why this documentation was not provided when originally requested.

Documentation Enclosed (Telephone prescriptions are not acceptable for post-audit documentation.)

- Original Hard Copy
- Prescriber Letter
- Pharmacy Computer System Documentation
- Other _____

Pharmacy Attestation

As the pharmacy representative who submitted this appeal, I attest that the documentation I'm submitting for review is true and correct, was used when dispensing the prescription, and has not been altered, backdated, or recreated after the order was filled.

Pharmacy Representative Signature _____

Printed Name _____ Date _____