

STANDARD PHARMACY REIMBURSMENT APPEAL FORM

Pursuant to Tenn. Code Ann. § 56-7-3206(c)(2)(D)

APPELLANT INFORMATION

First Name	Last Name
Phone	E-mail
Appellant Name if Different from Pharmacy	
PHARMACY INFORMATION	
Pharmacy Name	Pharmacy Email Address
Pharmacy National Council for Prescription Drug I	Programs (NCPDP) Number
Pharmacy Address Line 1	Pharmacy Address Line 2
City	State
Zip	Pharmacy Phone Number
PHARMACY BENEFITS MANAGER (PBM) INFORMATION	
Name of PBM or Health Insurance Company	PBM Claim Number

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CONSUMER'S CLAIM INFORMATION	
Bin Number	Processor Control Number
Group	Prescription Number
First Name of Insured	Last Name of Insured
Insurance ID Number	
Drug or Device Name	Fill Date
Quantity Dispensed	Drug or Device Manufacturer
Reimbursement Amount	Actual Cost
Name of Wholesaler or Manufacturer if not obtained	d from Wholesaler
National Drug Code or Unique Device Identifier	
Pharmacy's Point of Contact at Wholesaler or Manu	utacturer if not obtained from Wholesaler

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ATTACHMENT PAGE FOR EXHIBITS TO SUPPORT ACTUAL COST

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