

RETURN TO

Staple Here

FIRST CLASS MAIL



PLACE
STAMP
HERE

DEPARTMENT OF PUBLIC WELFARE - OMAP
DIVISION OF PHARMACY PROGRAM OPERATIONS
DRUG REFERENCE FILE UNIT
PO BOX 2675
HARRISBURG, PA 17105-2675



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PHARMACY FORM - NDC

This form is a self-contained mailer. In the event you have had a pharmacy claim rejected through the on-line system as “NDC not on file,” please verify that the NDC code transmitted is the same as the NDC on the product’s container. If the two are different, please resubmit the correct NDC code through the on-line system. If the two are identical and you feel that the drug should be compensable under Pennsylvania Medical Assistance Program regulations, complete **all** the items listed below with the required information, including pharmacy name, address, and zip code. Fold the form on the line indicated, seal with a staple where indicated, stamp with first class postage, and mail.

NDC NUMBER _____ - _____ - _____	NAME OF DRUG _____	Rx/OTC _____	STRENGTH _____	DOSAGE FORM - tab, cap, gel, etc. _____
FULL NAME OF LABELER _____				PACKAGE SIZE _____

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Date of Service ____ / ____ / ____	IS THERE A DENIED CLAIM FOR THIS DRUG? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, ICN # (13 digits) _____
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PRINT NAME OF INDIVIDUAL COMPLETING THIS FORM _____	TELEPHONE NUMBER _____ - _____ - _____
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PLEASE COMPLETE THE SECTION BELOW
TO ENSURE RETURN OF FORM

<p>PLEASE PRINT LEGIBLY PHARMACY NAME, ADDRESS AND ZIP CODE</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>FOR PUBLIC WELFARE USE</p> <p><input type="checkbox"/> DRUG EFFECTIVE SINCE _____</p> <p><input type="checkbox"/> DRUG NOT COMPENSABLE UNDER PENNSYLVANIA MA REGULATIONS</p> <p><input type="checkbox"/> OTHER _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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