



MaxCare Prescription Benefit Services  
MAC Appeal Worksheet

**This Form Is For Generic Medications Only**

Pharmacy  
Name:

Date  
Received:

**Please Attach a Copy of the Wholesaler's Invoice on the Specific Prescription in Question -  
Without an Invoice, MaxCare cannot process the request.**

NCPDP #

Date Filled:

NPI #

Name of Person Requesting Adjustment:

Pharmacy Phone #

Pharmacy Fax #

Rx #

NDC #

Drug Name/Strength/Dosage Form:

Net Acquisition Cost:

(Please specify if cost is per unit or bottle)

Where Drug Was Purchased:

(Wholesaler: McKesson, AmeriSource Bergen, Cardinal, Morris Dickson, Anda, VIP, Endo, Etc.)

Provide Specific Information on  
the Rx in Question:

Metric Quantity Dispense :

Ingredient Cost Paid by PBM:

Dispensing Fee:

Total Paid by PBM:

INTERNAL USE ONLY

Fax: 405-525-7523

[www.maxcarerx.com](http://www.maxcarerx.com)