

## MAC Request Form

Please use this form to notify Ohio Medicaid's Fee-for-Service plan about recent changes in a generic drug price(s) that impact your ability to fill prescriptions for our patients. This form is to be completed by the pharmacy and faxed, along with a copy of the invoice (including any credits or chargebacks) and the de-identified claim, directly to Change Healthcare at (844-592-7008). Change Healthcare will research the issue and reply to the pharmacy with any changes in the rate. Please be aware that Ohio Medicaid does not retroactively change reimbursement rates; any change to a MAC rate as a result of a MAC Request Form will only impact future pharmacy claims. Thank you.

<b>NPI #</b>	
<b>Pharmacy Name</b>	
<b>Contact Name</b>	
<b>Pharmacy Phone Number</b>	
<b>Pharmacy Fax Number</b>	
<b>Pharmacy Email Address</b>	
<b>Drug Name</b>	
<b>NDC</b>	

Please include:

- Copy of recent invoice for the claim in question. All invoice information must be visible.
- Copy of the claim (with all PHI removed or blacked out) initiating the inquiry for reimbursement review. The claim must show RX#, NDC#, DOS and amount paid.

Comments:

Thank you,  
Ohio MAC Helpdesk  
(844) 559-0607 Phone  
(844) 592-7008 Fax  
PBA\_OHSMAC@changehealthcare.com