



## MAC Reimbursement Rate Dispute

Please provide as much information as possible and email the completed form to [macresolution@optum.com](mailto:macresolution@optum.com).

### Pharmacy Information

Pharmacy Name \_\_\_\_\_  
Pharmacy Address \_\_\_\_\_  
Contact Name \_\_\_\_\_  
Contact Phone Number \_\_\_\_\_ Contact Email \_\_\_\_\_  
Pharmacy NCPDP # \_\_\_\_\_ Pharmacy Chain # \_\_\_\_\_

### Medication Information 1

Patient ID # \_\_\_\_\_ WC Claim # \_\_\_\_\_  
Rx # \_\_\_\_\_ Rx Date \_\_\_\_\_  
Medication Name \_\_\_\_\_ NDC # \_\_\_\_\_  
Quantity/Day Supply \_\_\_\_\_ Fill Type  Initial Rx  Refill  
Acquisition Price \_\_\_\_\_ Wholesaler \_\_\_\_\_ Purchase Date \_\_\_\_\_

### Medication Information 2

Patient ID # \_\_\_\_\_ WC Claim # \_\_\_\_\_  
Rx # \_\_\_\_\_ Rx Date \_\_\_\_\_  
Medication Name \_\_\_\_\_ NDC # \_\_\_\_\_  
Quantity/Day Supply \_\_\_\_\_ Fill Type  Initial Rx  Refill  
Acquisition Price \_\_\_\_\_ Wholesaler \_\_\_\_\_ Purchase Date \_\_\_\_\_

### Medication Information 3

Patient ID # \_\_\_\_\_ WC Claim # \_\_\_\_\_  
Rx # \_\_\_\_\_ Rx Date \_\_\_\_\_  
Medication Name \_\_\_\_\_ NDC # \_\_\_\_\_  
Quantity/Day Supply \_\_\_\_\_ Fill Type  Initial Rx  Refill  
Acquisition Price \_\_\_\_\_ Wholesaler \_\_\_\_\_ Purchase Date \_\_\_\_\_

### Medication Information 4

Patient ID # \_\_\_\_\_ WC Claim # \_\_\_\_\_  
Rx # \_\_\_\_\_ Rx Date \_\_\_\_\_  
Medication Name \_\_\_\_\_ NDC # \_\_\_\_\_  
Quantity/Day Supply \_\_\_\_\_ Fill Type  Initial Rx  Refill  
Acquisition Price \_\_\_\_\_ Wholesaler \_\_\_\_\_ Purchase Date \_\_\_\_\_

### Additional Information

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*Note - MAC Price Inquiries must be submitted with a properly authorized NDA and are available for medications currently being dispensed in relation to a claim processed by the Tmesys network and in compliance with existing legal requirements. Optum may request additional information such as an invoice for verification.*