Kentucky Medicaid MAC Price Research Request Form

By submitting this form, I am requesting that Magellan Medicaid Administration research the Kentucky Medicaid Maximum Allowable Cost (MAC) List price of the drug listed on this form and respond about product availability or a price modification based on information provided in the "Comments" section below.

*** DENOTES REQUIRED FIELDS**

DATE: _____

Provider Information		
*PROVIDER NAME:	*CONTACT NAME:	
*PHONE NUMBER:	*FAX NUMBER:	*NPI NUMBER:

Drug Information			
*DRUG NAME:	*DRUG STRENGTH:	*DRUG DOSAGE FORM:	
*NDC NUMBER:	RECIPIENT ID NUMBER:	*RX NUMBER:	
*PROVIDER ACQUISITION COST:	*DAW CODE:	QUANTITY DISPENSED:	*DATE OF SERVICE:

Comments

Magellan Medicaid Administration's Use Only – Do Not Mark in this Area!
RESPONSE DATE: _____
RESPONSE: _____
_____
_____

Return this form with a copy of the invoice listing the current acquisition cost to
Magellan Medicaid Administration, Inc.
Attn: MAC Department
Fax: 888-656-1951 or
E-mail: StateMACProgram@magellanhealth.com
Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.

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