**Claims Dispute Form**

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| --- | --- |
| **Date of Dispute:** |  |
| **Pharmacy Name:** |  | **Pharmacy NPI:** |  |

RxPreferred maintains an ongoing pharmacy claims compliance and review program. RxPreferred is committed to working with you to continuously increase the overall quality of our Provider Networks. If you do not agree with the remittance invoice that you have received, we would like to provide you with an opportunity to dispute the invoice findings. **Please complete this form, providing a detailed reasoning for your dispute, attach additional supporting information if needed.**

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| --- | --- | --- | --- | --- | --- |
| **Fill Date** | **Rx Number** | **Member ID** | **Member DOB** | **First Name** | **Last Name** |
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| **Reason For Dispute:** |
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**Inside 30 day: To be filled out by RxPreferred employee:**

RxPreferred Employee Name: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RxPreferred Employee Signature: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Outside 30 Day : To be filled out by Pharmacy and returned to RxPreferred:**

I hereby certify this information to be true and correct.

Supervising Pharmacist Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervising Pharmacist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Once completed, please fax form and any additional documentation to 888-631-0862 or email to support@rxpreferred.com**