



MEDICATION REIMBURSEMENT DISCREPANCY FORM

1. Submit this form to request a medication cost discrepancy review between the Physicians Plus reimbursement rate and your acquisition cost (*one drug per form*).
2. All information requested on the form must be completed.
3. Include a copy of the **CURRENT INVOICE** with acquisition cost of the medication. Any forms submitted without a current invoice will **NOT** be reviewed.
4. Discrepancy forms are reviewed bi-weekly.
5. Submitting the form does **NOT** guarantee a change in reimbursement will occur.
6. The person submitting the form will be notified **ONLY** if a reimbursement rate change occurs as a result of this form.
7. If approved, the original prescription claim must be reversed and resubmitted for reimbursement at the updated price.

Medication Information	
Name of Medication, Strength, and Dosage Form:	
Manufacturer:	
NDC Number:	Package Size:
Pharmacy Acquisition Cost:	
Member ID (<i>including person code</i>):	
Rx Number:	Rx Claim Date:

Pharmacy Information	
Individual Submitting Request (Print):	
Pharmacy Name:	
Address:	
NABP or NPI Number:	E-Mail Address:
Telephone Number:	Fax Number:
Authorized Signature:	Date Form Submitted:

Mailing Address:

Physicians Plus Insurance Corporation
 Attn: Pharmacy Services
 P.O. Box 2078
 Madison, WI 53701-2078

Physicians Plus Pharmacy Services:

Fax: (608) 327-0324
 Voice: (608) 260-7803
 Email: pharmacyinfo@pplusic.com