GOOLD HEALTH SYSTEMS

MEPOP

ADJUSTMENT / SUPPLEMENTAL PAYMENT REQUEST FORM

Return to:

Goold Health Systems, Inc.
5 Community Drive, P.O. Box 1090, Augusta, Maine 04332-1090
Fax # 1-800-408-1088

Name of Client:
Street Address:
City or Town:

Plan Name:

Pharmacy Name, Address,NABP# and NPI#

Patient's Number:

Remittance Date:		Claimed Amt.		Amt. Prev. Paid:		Comments:												
Rx Number:	O/R	Prescriber DEA/ BNDD #		Prescriber Name			Date Prescribed		Date filled						Quantity		Est. Days	
PA #	MN	Drug Name, Strength,Dosage, mfg.	N D C												Other coverage		total billed	

Remittance Date:		Claimed Amt.		Amt. Prev. Paid:		Comments:												
Rx Number:	O/R	Prescriber DEA/ BNDD #		Prescriber Name			Date Prescribed		Date filled						Quantity		Est. Days	
PA #	MN	Drug Name, Strength,Dosage, mfg.	N D C												Other coverage		total billed	

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