



MEPART D

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

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| Pharmacy Name, Address, NABP# and NPI # |
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|-----------------|
| Name of Client: |
| Street Address: |
| City or Town: |

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| Plan Name: |
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| Patient's Number: |
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| Comments: | | | | Other Coverage Code: | | Deductible: | | | | Gap: | | | |
| Rx Number: | Ref# | Prescriber DEA/ BNDD # | Prescriber Name | | Date Prescribed | | Date filled | | Quantity | | Est. Days | | |
| PA # | MN | Drug Name, Strength, Dosage, mfg. | | N | | | | | | | PDP Copay: | total billed | |
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| Comments: | | | | Other Coverage Code: | | Deductible: | | | | Gap: | | | |
| Rx Number: | Ref# | Prescriber DEA/ BNDD # | Prescriber Name | | Date Prescribed | | Date filled | | Quantity | | Est. Days | | |
| PA # | MN | Drug Name, Strength, Dosage, mfg. | | N | | | | | | | PDP Copay: | total billed | |
| | | | | D | | | | | | | | | |
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| Comments: | | | | Other Coverage Code: | | Deductible: | | | | Gap: | | | |
| Rx Number: | Ref# | Prescriber DEA/ BNDD # | Prescriber Name | | Date Prescribed | | Date filled | | Quantity | | Est. Days | | |
| PA # | MN | Drug Name, Strength, Dosage, mfg. | | N | | | | | | | PDP Copay: | total billed | |
| | | | | D | | | | | | | | | |
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| Comments: | | | | Other Coverage Code: | | Deductible: | | | | Gap: | | | |
| Rx Number: | Ref# | Prescriber DEA/ BNDD # | Prescriber Name | | Date Prescribed | | Date filled | | Quantity | | Est. Days | | |
| PA # | MN | Drug Name, Strength, Dosage, mfg. | | N | | | | | | | PDP Copay: | total billed | |
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