

OHIO DEPARTMENT OF MEDICAID

**MAC Request**

Please use this form to notify Ohio Medicaid’s Fee-for-Service plan about recent changes in a generic drug price(s) that impact your ability to fill prescriptions for our patients. This form is to be completed by the pharmacy and faxed, along with a copy of the invoice (including any credits or chargebacks) and the de-identified claim, directly to Change Healthcare at (844-592-7008). Change Healthcare will research the issue and reply to the pharmacy with any changes in the rate. Please be aware that Ohio Medicaid does not retroactively change reimbursement rates; any change to a MAC rate as a result of a MAC Request Form will only impact future pharmacy claims. Thank you.

NPI Number	Pharmacy Name
Contact Name	Pharmacy Phone Number
Pharmacy Fax Number	Pharmacy Email Address
Drug Name	NDC

**Please include**

- Copy of recent invoice for the claim in question. All invoice information must be visible.
- Copy of the claim (with all PHI removed or blacked out) initiating the inquiry for reimbursement review. The claim must show RX#, NDC#, DOS and amount paid.

**Comments**

**Ohio MAC Helpdesk**

**Phone (844) 559-0607**

**Fax (844) 592-7008**

**PBA\_OHSMAC@changehealthcare.com**