

Beneficiaries Notice – Triplicate Form Request

REQUEST DATE:

/ /

REQUESTER OR CONTACT PERSON INFORMATION

REQUESTER'S OR CONTACT PERSON'S FULL NAME:

[illegible]

REQUESTER'S OR CONTACT PERSON'S EMAIL:

[illegible]

REQUESTER'S OR CONTACT PERSON'S PHONE NUMBER:

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PHARMACY PHYSICAL ADDRESS:

[illegible]

CITY:

[illegible]

STATE:

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ZIP:

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PHARMACY INFORMATION

PHARMACY NAME:

[illegible]

PHARMACY PHONE NUMBER:

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PHARMACY FAX NUMBER:

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PHARMACY NPI #:

[illegible]

Beneficiaries Notice Requirements

- The Department of Health Care Finance (DHCF) is requiring the District Medicaid program's participating pharmacies to distribute individualized written notices to Medicaid beneficiaries whose prescription medication claim requests are denied after adjudication at the pharmacy point of sale. The notice explains the rights a beneficiary has when a prescription claim is denied by Medicaid, the responsibilities of the beneficiary, the responsibilities of the pharmacists, and provides a contact number for the District Medicaid pharmacy benefit manager (PBM) call center. A beneficiary who continues to believe the claim should be approved by Medicaid may request a Fair Hearing before an Administrative Law Judge.
- This applies to all beneficiaries who are served by DC Medicaid, including those enrolled in all DC Medicaid Managed Care Organizations as follows: Amerigroup DC, AmeriHealth Caritas DC, and MedStar Family Choice DC, and Health Services for Children with Special Needs (HSCSN).
- Additional information is available at [Written Pharmacy Point of Service \(POS\) Notice](https://dhcf.dc.gov/node/1661466). (URL: <https://dhcf.dc.gov/node/1661466>)

ACTION REQUIRED. PLEASE CHECK ALL THAT APPLY

1. **Form quantity requested:** ☐ 100 ☐ 200 ☐ 300 ☐ Other: _____
2. **Are you returning forms?** ☐ Yes ☐ No

If yes, how many forms are you returning? _____

ADDITIONAL INFORMATION

REQUESTOR'S SIGNATURE: _____

REQUESTOR'S PRINT NAME: _____ DATE _____