MCO PHARMACY PROVIDER NETWORK REIMBURSEMENT INQUIRY REPORT

MCO NAME:

PBM:
BIN:
PCN:

PHARMACY NAME:
PHARMACY NPI:
PHARMACY CONTACT NAME:
PHARMACY CONTACT PHONE:
PHARMACY CONTACT EMAIL:

Date Filled	RX Number	Quantity Dispensed	Dispensed Product Name	Product NDC	Ingredient cost submitted	Ingredient cost reimbursed	Dispensing fee paid	Total Reimbursement	Gross profit/(loss)	Comments