



MAC Price Inquiry and Research Request Form

Client: _____

Date: _____

To: Rebate/MAC Department
Fax: 804-217-7911
E-mail: Rebate@FHSC.com

Provider Name*: _____

Provider Phone*:

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Provider Fax*:

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Provider NABP #:

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Provider Contact*: _____

Drug Name, Strength, & Dosage Form*: _____

NDC#*:

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Member ID #: _____ **Rx#:** _____

Price*: _____

Comments: _____

Response Date: _____

Response: _____

*Required Field (red)