

## STANDARD PHARMACY REIMBURSEMENT APPEAL FORM

*Pursuant to Tenn. Code Ann. § 56-7-3206(c)(2)(D)*

Or email completed form to:  
PharmacyAppeals@vyltone.com

### APPELLANT INFORMATION

First Name

Last Name

Phone

E-mail

Appellant Name if Different from Pharmacy

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### PHARMACY INFORMATION

Pharmacy Name

Pharmacy Email Address

Pharmacy National Council for Prescription Drug Programs (NCPDP) Number

Pharmacy Address Line 1

Pharmacy Address Line 2

City

State

Zip

Pharmacy Phone Number

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### PHARMACY BENEFITS MANAGER (PBM) INFORMATION

Name of PBM or Health Insurance Company

PBM Claim Number

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**CONSUMER'S CLAIM INFORMATION**

Bin Number

Processor Control Number

Group

Prescription Number

First Name of Insured

Last Name of Insured

Insurance ID Number

Drug or Device Name

Fill Date

Quantity Dispensed

Drug or Device Manufacturer

Reimbursement Amount

Actual Cost

Name of Wholesaler or Manufacturer if not obtained from Wholesaler

National Drug Code or Unique Device Identifier

Pharmacy's Point of Contact at Wholesaler or Manufacturer if not obtained from Wholesaler

**ATTACHMENT PAGE FOR EXHIBITS TO SUPPORT ACTUAL COST**