CHANGE HEALTHCARE™

Please Fax reversals on this form to: 1-800-408-1088

PHARMACY NAME_____

*NABP# **(REQUIRED)** _____

***NPI# (REQUIRED)**_____

RX NUMBER	FILL DATE	PLAN

*** All fields must be filled in or request will be faxed back**

SENT BY:_____

Check here if return call required_____

Phone #_____-_____-_____

E-Mail Address:_____

PLAN: Medicaid, ADAP, DEL, General Asst., TB, Tobacco, MEPARTD/WRAP