



# Kansas Medical Assistance Program

P.O. Box 3571  
Topeka, KS 66601-3571

Provider Line: 1-800-933-6593  
Consumer Line: 1-800-766-9012

*From the office of the Fiscal Agent*

## NDC Pricing Inquiries

### KMAP Request Form

*This form should not be used for dispense as written (DAW) pricing inquiries. Requests for brand reimbursement (DAW) on generically available products require completion of a MedWatch form.*

Date of request \_\_\_\_\_

Pharmacy name \_\_\_\_\_

Pharmacy KMAP ID \_\_\_\_\_ NPI # \_\_\_\_\_

Pharmacy phone # \_\_\_\_\_ Pharmacy fax # \_\_\_\_\_

Pharmacy contact \_\_\_\_\_ RX # \_\_\_\_\_

Drug \_\_\_\_\_ NDC \_\_\_\_\_

Drug cost \_\_\_\_\_ Date of invoice \_\_\_\_\_

Beneficiary name \_\_\_\_\_ Beneficiary ID \_\_\_\_\_

Dispense date \_\_\_\_\_ Billed date \_\_\_\_\_

Additional information: \_\_\_\_\_

**Fax a completed form AND a copy of your invoice to the KMAP Pharmacy department at 785-267-7687.**

This information will be reviewed by the KMAP Pharmacy department, and any recommendations will be presented to the KDHE-DHCF Pharmacy program manager for consideration. If you do not receive a reply within 14 business days, contact the KMAP Pharmacy Help Desk at 1-866-405-5200.

**Note: This form must be fully completed to process your request.**

#### FOR OFFICE USE ONLY

Date received by KMAP Pharmacy department \_\_\_\_\_

Approved: YES NO

Recommended reimbursement \_\_\_\_\_ Effective date \_\_\_\_\_

KDHE-DHCF program manager signature \_\_\_\_\_ Date \_\_\_\_\_