Michigan MAC Pricing Request Form

By submitting this form, I am requesting that Magellan Medicaid Administration research the Michigan Medicaid Maximum Allowable Cost (MAC) List price of the drug listed on this form and respond about product availability or a price modification based on information provided in the "Comments" section below.

*** DENOTES REQUIRED FIELDS**

DATE: _____

Provider Information		
***FACILITY NAME:**		***PROVIDER CONTACT NAME:**
***PHONE NUMBER:**	***FAX NUMBER:**	***NPI NUMBER:**

Drug Information			
***DRUG NAME:**	***DRUG STRENGTH:**		***DRUG DOSAGE FORM:**
***NDC NUMBER:**	**RECIPIENT ID NUMBER:**		***RX NUMBER:**
***PROVIDER ACQUISITION COST:**	***DAW CODE:**	**QUANTITY DISPENSED:**	***DATE OF SERVICE:**

Comments

Magellan Medicaid Administration's Use Only – Do Not Mark in this Area!
RESPONSE DATE: _____
RESPONSE: _____
_____
_____

Return this form with a copy of the invoice listing the current acquisition cost to
Magellan Medicaid Administration, Inc.
Attn: State MAC Department
Fax: 888-656-1951 or
E-mail: StateMACProgram@MagellanHealth.com
Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.

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