

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.

Please Note: A copy of the acquisition cost invoice is required.

*** 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:	*PROVIDER ACQUISITION COST:	

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: 1-888-656-1951 or

E-mail: StateMACProgram@MagellanHealth.com

Note: Processing May Be Delayed if Information Submitted is Illegible or Incomplete.

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