Gateway Health

SECOND-LEVEL PHARMACY PRICING DISPUTE RESOLUTION REQUEST FORM

Please complete and email all requested information below including the required documentation listed below, along with any supporting documentation as applicable to Gateway Health℠ Pharmacy Services at RxPricingDisputes@GatewayHealthPlan.com.

PROVIDER INFORMATION

Pharmacy Name:	Pharmacy Contact Name:
Pharmacy NCPDP:	Pharmacy Contact Direct Phone:
Pharmacy NPI:	Pharmacy Contact Email:

CLAIM INFORMATION

Date of Fill:	Prescription Number:
Gateway Member ID:	Gateway Member Name:
	Gateway Member Date of Birth:

DRUG INFORMATION

Drug Name and Strength:	
NDC:	
Quantity:	Days' Supply:

PRICING/DISPUTE INFORMATION

Disputed Reimbursement Amount from PBM:	
Actual Acquisition Cost (Net Discounts):	
Date of Appeal with PBM:	
PBM Decision:	Date of PBM Decision:

Please indicate rationale for disagreement with PBM decision, including supporting evidence where applicable: _____

_____

_____

_____

_____

Please Attach the Following Information to this Form:

☐ Documentation of Actual Acquisition Cost (net any discounts)
☐ Copy of request Submitted to PBM and Assigned Case Number

PBM CONTRACT INFORMATION

Contract Arrangement Type: ☐ Direct Contract with PBM ☐ PSAO Contract ☐ Other (Explain): _____

Name of PSAO (If Applicable):

IF CONTRACT TYPE IS 'PSAO', attach evidence of PSAO involvement, including acceptance or rejection of the first-level review decision.

ADDITIONAL SUPPORTING INFORMATION OR RATIONALE

☐ **In submitting this second-level pricing dispute, I attest that I have exhausted all remedies available to me against the PBM including, but not limited to, a first-level pricing dispute.**

Signature	Name and Title	Date