NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Request for Adjustments

DATE: ____________________

PHARMACY NAME: ______________________________ PROVIDER NUMBER: ____________________

	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM DATE ____________	____________	____________
PRESCRIBER # ____________	____________	____________
TRACE # ____________	____________	____________
RX # ____________	____________	____________
DIN ____________	____________	____________
QTY ____________	____________	____________
TOTAL BILLED ____________	____________	____________
MARK UP ____________	____________	____________
FEE ____________	____________	____________

	REASON FOR ADJUSTMENT	PHARMACARE REPLY
CLAIM DATE ____________	____________	____________
PRESCRIBER # ____________	____________	____________
TRACE # ____________	____________	____________
RX # ____________	____________	____________
DIN ____________	____________	____________
QTY ____________	____________	____________
TOTAL BILLED ____________	____________	____________
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FEE ____________	____________	____________

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TOTAL BILLED ____________	____________	____________
MARK UP ____________	____________	____________
FEE ____________	____________	____________

NOVA SCOTIA