Manufacturer TRICARE Retail Refund Program 340b Verification Form

Note: This form is to be completed by an authorized representative (Pharmacist, Technician, or other Pharmacy Representative) at the Covered Entity (Pharmacy) that can verify that the prescription was dispensed/billed using a 340b product.

1. To be completed by the Manufacturer:

Manufacturer Name:	Labeler:	Billing Quarter:
Phone:	Fax:	

2. To be completed by the Manufacturer and the Covered Entity (Pharmacy):

	A. Prescription Number	B. Date of Service	C. 340b Product Dispensed?	
			Yes	No
	Example: 999999	**05/01/15**	✓	
1				
2				
3				
4				
5				
6				
7				
8				

3. To be completed by the Covered Entity (Pharmacy):

Covered Entity Name (Pharmacy Name):	NPI:
Address:	Phone:
Email:	Fax:

Authorized Representative Signature **Date**

Authorized Representative Title **Print Name**

Instructions for Completing the TRICARE Retail Refund Program
340b Verification Form

Please complete this form as instructed below.

Instructions for the Manufacturer:

Please complete the form in its entirety. Missing or invalid information will delay the processing of your dispute. Completed forms are to be emailed to the Defense Health Agency (DHA) at dha.ncr.healthcare-ops.mbx.ufvarr-requests@health.mil.

Instructions for Completing the Form:

Section 1: To be completed by the Manufacturer

Section 2: To be completed by the Manufacturer and the Covered Entity (Pharmacy)

Manufacturer:

A. Prescription number (RX#)
B. Date of service based on the utilization data provided to the manufacturer.

Covered Entity (Pharmacy):

C. Will verify that the prescription was or was not billed/dispensed using a 340b product and will check yes or no.

Section 3: To be completed by the Covered Entity (Pharmacy)

The authorized representative will sign, print name, date, and provide title; i.e.; Pharmacist, Technician, 340b Specialist, etc.