NOVA SCOTIA PROVINCIAL PHARMACARE PROGRAMS
Request for Adjustments

DATE: _______________

PHARMACY NAME: _________________________________ PROVIDER NUMBER: ________________

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

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

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

NOVA SCOTIA