NS PHARMACARE PROGRAMS – REQUEST FOR ADJUSTMENTS

Date: _____

PHARMACY NAME: _____ NUMBER: _____

PAYMENT STATEMENT DATE: _____ CLAIM NUMBER: _____ REFERENCE NUMBER: _____ HEALTH CARD NUMBER: _____ RX NUMBER: _____ DATE RX DISPENSED: _____ CO-PAY CHARGED: _____	REASON FOR ADJUSTMENT	PHARMACARE REPLY
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