Kentucky Department of Insurance
Maximum Allowed Cost (MAC) Complaint

P.O. Box 517 Frankfort, KY 40602-0517
Fax Number 502-564-6090

Pharmacy name | NPI#

Contact person | Phone #

Email address

Mailing address

Patient name

Primary insurance or Medicaid MCO

Secondary insurance

Name of Pharmacy Benefit Manager (PBM)

RX# | Date of fill

NDC# | Quantity dispensed

Name of medication

Date PBM denied appeal (Provide copy of denial)

Cost of medication (Provide copy of invoice) $ 0.00

Dispensing Fee $ 0.00

Co-Pay collected $ 0.00

Reimbursement amount (medication only) $ 0.00

COMMENTS: