Workers Compensation Rx Solutions, Inc.
P.O. BOX 97693
LAS VEGAS, NV 89193
(888) 907-9770

Formal Request for Reconsideration- Additional Payment Request

Carrier Info:

Patient Name:
Claim#:
DOS:
INVOICE#:
Amount Due $

Our record indicated that the above referenced patient incurred a work related injury. The referenced pharmacy outsources their workers' compensation prescription research, claim preparation, and billing to Workers Compensation Rx Solutions. As the assignee of the prescription claim(s) referred to in this letter, WCRx Solutions is the sole owner of such claims(s).

Enclosed is an invoice(s) and explanation of benefits for dates of service that have been incorrectly paid and/or processed. At this time, we are filing a request for reconsideration for the follow reasons:

X MEDICATION NOT PAID ACCORDING TO THE STATE MANDATED FEE SCHEDULE; PLEASE REPROCESS THE BILL FOR ADDITIONAL PAYMENT USING THE AWP AT THE TIME OF SERVICE AND THE APPLICATE STATE FEE SCHEDULE

X THERE ARE NO PHARMACEUTICAL SERVICES CONTRACTUAL AGREEMENTS BETWEEN THE PROVIDING PHYSICIAN AND/OR PHARMACY AND/OR THIRD PARTY BILLER AND THE PHARMACY BENEFIT MANAGER AND/OR NETWORK PLAN LISTED ON THE EOR.

PLEASE REVIEW FOR ADDITIONAL PAYMENT AS NO CONTRACT EXISTS TO ALLOW FOR DISCOUNTED PAYMENT.

ALTERNATIVELY, SHOULD YOUR COMPANY MAINTAIN THE ORIGINAL BILL REVIEW REDUCTION, PLEASE PROVIDE PROOF OF CONTRACTUAL AGREEMENT AS WE ARE UNAWARE OF ANY THAT EXIST BETWEEN OUR COMPANY, OR THOSE WE REPRESENT, AND THE PBM.

Thank you for your expedited response.