Manufacturer TRICARE Retail Refund Program 340b Verification Form

1. To be completed by the Manufacturer:

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

2. To be completed by the Covered Entity:

Covered Entity Name:	NPI:
Address:	Phone:
	Fax:

This form is to be completed by an authorized representative at the Covered Entity that can verify that the prescription was dispensed/billed using a 340b product.

3. To be completed by the Manufacturer and the Covered Entity:

	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				

4. To be Completed by the Covered Entity:

_____ _____

Signature **Date**

_____ _____

Print Name **Title**

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.

Section 1: To be Completed by the Manufacturer

Section 2: To be Completed by the Covered Entity

Section 3: To be Completed by the Manufacturer and Covered Entity

Manufacturer:

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

Covered Entity:

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

Section 4: To be Completed by the Covered Entity

The authorized representative will sign, print name, date, and provide title; i.e.; Pharmacist.

Completed Forms:

Manufacturers: Please email all completed forms to the Defense Health Agency (DHA) at UFVARR_Requests@mail.mil.