PROVIDER TRANSACTION ADJUSTMENT FORM

FOR USE BY PHARMACY PERSONNEL ONLY - ALL SECTIONS MUST BE COMPLETED

NB: Submit by fax to 754-2640 or by email to customercare@nhf.org.jm

PROVIDER: ____________________________ **NHF PROVIDER NO:** ________________ **JADEP PROVIDER NO:** ________________________

DATE OF TRANS-ACTION	RX #	MEMBER ID#	DRUG NAME & STRENGTH	QTY	DAYS SUPPLY	NDC #	TOTAL COST	REASON FOR ADJUSTMENT/S	TYPE OF ADJUST-MENT

PREPARED BY: ……………….……………… **TITLE:** ……………………….…..…….. **SIGNATURE:** ……………….............................. **DATE:** ………………………

SERVICE REQUEST KEY: **REV -** REVERSAL OF TRANSACTION
REP - REPOSTING OF TRANSACTION

Issue Date: August 21, 2017 Rev. 1.0