



# OMAC Dispute Resolution and Research Request

To: Oregon Pharmacy Call Center

Date \_\_\_\_\_

Fax to: 1-888-346-0178

Provider's Name \_\_\_\_\_

Provider's Phone \_\_\_\_\_

Provider's Fax \_\_\_\_\_

Provider's NPI# \_\_\_\_\_

Provider Contact \_\_\_\_\_

Drug Name \_\_\_\_\_  
(Strength and Dosage Form)

NDC# \_\_\_\_\_

Client ID# \_\_\_\_\_

RX# \_\_\_\_\_

Price for Drug \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

EDS Response Date \_\_\_\_\_

EDS Response  Approve  Deny

EDS Signature \_\_\_\_\_