

RETROACTIVE CLAIM FAX FORM

DATE FAXED	CONTACT
VENDOR #	PHARMACY NAME
FAX #	PHONE #

MEDICAID PROCESSING ONLY
FAX COMPLETED FORM TO 512-491-1958

REJECTION CODE Rejection Code 75 (Prior Authorization Required)
 CHECK ALL Rejection Code 76 (Plan Limitations Exceeded)
 THAT APPLY Rejection Code 81 (Claim Too Old)

REV 09 / 2009

Instructions available via the Vendor Drug Program website (www.txvendordrug.com).

CLIENT NAME	DOB	CARDHOLDER ID	OLDEST CLAIM DATE	# CLAIMS
CERTIFIED DATE	EFFECTIVE DATE	MEDICARE	CLAIMS PAID / DATE	
ADMIT DATE	PROCESS DATE	LIMITED <input type="checkbox"/> UNLIMITED <input type="checkbox"/>		
PHARMACY COMMENTS				
MEDICAID COMMENTS				

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