PROVIDER TRANSACTION ADJUSTMENT FORM

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

NB: Submit by email to customercare@nhf.org.jm

PROVIDER: _____ **NHF PROVIDER NO:** _____ **JADEP PROVIDER NO:** _____

DATE OF TRANSACTION	RX #	MEMBER ID#	DRUG NAME & STRENGTH	QTY	DAYS SUPPLY	NDC #	TOTAL COST	REASON FOR ADJUSTMENT/S	TYPE OF ADJUSTMENT

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

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

Issue Date: August 21, 2017

Rev. 3.0 – April 25, 2025