Instructions for Completing the TRICARE Retail Refund Program 340b Verification Form

Please complete this form as instructed below.

Instructions for the Manufacturer:

Please provide all requested information on the form provided below. Missing or invalid information will delay the processing of your dispute. Completed forms are to be emailed to the Defense Health Agency (DHA) at dha.ncr.healthcare-ops.mbx.ufvarr-requests@health.mil.

Notes for Completing the Form:

This form is to be completed by an authorized representative (Pharmacist, Technician, or other Pharmacy Representative) at the Covered Entity (Pharmacy) that can verify that the prescription was dispensed/billed as a 340b product.

This form is intended to be filled out by **ONLY 1 Covered Entity (Pharmacy)** as designated by their National Provider Identifier (NPI)

Please fill in all information requested. Any Missing or invalid information in (*) fields may delay the processing of your dispute or result in its rejection.

Section 1: To be completed by the Manufacturer

Use of the Manufacturer Name and Labeler ID under which the product was billed in the TRICARE Retail Refund Program (TRRP) is preferred.

Section 2: To be completed by Each Covered Entity (Pharmacy)

The Covered Entity (Pharmacy) should provide:

A. Name of the Pharmacy
B. Address
C. Nation Provider Identifier (NPI) or NCPDP
    i. NPI is preferred over the National Council for Prescription Drug Programs (NCPDP) number

Section 3: To be completed by the Manufacturer and Each Covered Entity (Pharmacy)

The Manufacturer should provide:

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

The Covered Entity (Pharmacy) should provide:

A. Verification that the prescription was or was not billed/dispensed as a 340b product by selecting yes or no.

The Authorized Representative will provide:

A. Signature and printed name
B. Date of Signature
C. Title
    i. i.e., Pharmacist, Technician, 340b Specialist, etc.

TRICARE Retail Refund Program

Manufacturer 340b Verification Form

Please fill in all information requested. Any missing or invalid information in (*) fields may delay the processing of your dispute or result in its rejection.

1. To be completed by the Manufacturer:

Manufacturer Name:	Labeler ID*:	Billing Quarter (YYYYQQ)*:

2. To be completed by Covered Entity(Pharmacy):

Covered Entity (Pharmacy Name):	Address:	NPI or NCPDP*:

3. To be completed by the Manufacturer and Each Covered Entity (Pharmacy):

	Prescription Number*	NDC	Date of Service*	Was the Product dispensed as 340b?	
				Yes	No
Ex:	000123456789	01234567891	dd/mm/yyyy	X	
1				☐	☐
2				☐	☐
3				☐	☐
4				☐	☐
5				☐	☐
6				☐	☐
7				☐	☐
8				☐	☐
9				☐	☐
10				☐	☐

Authorized Representative Signature*
Print Name

Date
Authorized Representative Title