

MMCAP Data Request Form



Minnesota Multistate Contracting Alliance for Pharmacy(MMCAP)

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www.mmcap.org

Date: _____

Requester Information:

Requester Name: _____

Facility / Vendor Name: _____

Address: _____

State: _____

Zip: _____

Work Phone: _____

E-Mail: _____

Please fill out the form below. When you are finished, please click the "Submit by Email" button at the top of the page to email your data request form to MMCAP.

Enter the Beginning Report Date: Enter the Report End Date:

Member (Facility/State) - State: Select State:

Vendor (Manufacturer):

Distributor (Wholesaler):

Please list your data request. Be very detailed in your instructions.