



Pharmacy Benefit Manager Complaint

Please note: This complaint form, all documents you send us, and any documents received by our office as a result of handling your complaint may be a public record, subject to Ohio's Public Records Act. This law requires all public records to be available for inspection by anyone, upon request. **WARNING: All documentation we receive will be imaged, and then destroyed. Make copies of your documents and send the copies to us. Do not send original records.**

If completing this form by hand, please use black or blue ink. DO NOT USE PENCIL.

Name:			
Phone Number:		e-mail address:	
Name of Pharmacy:			
Address:			
City:	State:	Zip:	County:
Name of Pharmacy Services Administration Organization (PSAO):			
Name of Pharmacy Benefit Manager (PBM):			
Name of Insurance Company:			
Name or Number of Insurance Plan:			
Type of Complaint (check one or more):			
<input type="checkbox"/>	Appeals	Date of Appeal: _____	
<input type="checkbox"/>	Licensure		
<input type="checkbox"/>	Pricing (If you have multiple examples pertaining to one PBM, please attach document(s) containing any additional examples.)		
	Prescription (Rx) Number: _____	Product Name: _____	
	NDC: _____	Date of Service: _____	
<input type="checkbox"/>	Other		
Briefly describe your complaint. Please attach copies of all relevant documents. (If you need more space, please attach additional sheets.)			
How would you like to see your complaint resolved?			
Please sign and date: To the best of my knowledge the above statement is correct. I understand that a copy of this form and any attachments may be sent to the insurance company or agent involved. I authorize the insurance company to release all the medical records relating to this complaint to the Ohio Department of Insurance, and I authorize the Ohio Department of Insurance to release medical records relating to this complaint to the insurance company or agent as necessary in order to resolve this complaint. I represent that I have the proper authority to execute this release.			
Your Signature			Date