

# Individual Consumer - Prescription Drug Complaint

Attn: PBM Unit

Tracking ID:

Alabama Department of Insurance  
Insurance Consumer Services Division  
201 Monroe Street, Suite 502 | Montgomery, AL 36104

State Use Only

[ConsumerServices@insurance.alabama.gov](mailto:ConsumerServices@insurance.alabama.gov)

Phone: (334) 241-4141

(PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

## Section I: **Before you file a Request for Assistance**

You should first contact the Health Insurer for your Prescription Drug Plan and attempt to resolve the issue(s). If you do not receive a satisfactory response, then fill out an Individual Consumer Prescription Drug Complaint Form. Complete this form and attach copies of any appeal denial and any important correspondence and/or documentation that relates to your request for assistance. **MAIL or email** to the appropriate address shown above.

### Individual Consumer – Prescription Drug Complainant

Individual Complainant (if individual filing)	Pharmacy Name	& Contact Person
Address	Address	Work Phone
City, State, Zip	City, State, Zip	Cell
Email	Phone	Email

## Section II: General Information

1. Name of Pharmacy Benefit Manager: \_\_\_\_\_
2. Name of Insurance Company: \_\_\_\_\_
  - a. What state did you live in when you purchased this policy? \_\_\_\_\_
3. Name of Physician/Prescriber: \_\_\_\_\_  
Covered Individual: \_\_\_\_\_ a. CI id/Plan #: \_\_\_\_\_  
b. Date of Birth \_\_\_\_\_ c. Rx # \_\_\_\_\_ d. Drug Name: \_\_\_\_\_  
e. Claim # \_\_\_\_\_
4. Are you represented by legal counsel? (Check One)  Yes  No  
If yes, name of Attorney: \_\_\_\_\_
5. Does your complaint involve a **Self-Funded Health Benefit Plan**? (Check One)  Not sure  Yes  No

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## Section III: PBM Problem

6. Describe your Complaint Problem in Detail (use additional paper, if needed):
- Provide Prescription Receipts and other detailed documentation supporting your complaint.
  - **SIGN** this Complaint Form before filing.

**What do you consider to be a fair resolution?**

The Insurance Commissioner is authorized to send a copy of this complaint and any follow-up documents to any insurance company, insurance producer, or insurance agency involved in the complaint to investigate my concerns. I authorize the release of all relevant information, including medical records, to the Insurance Commissioner's office for its review of this matter. I understand the Insurance Commissioner's office cannot act as my attorney, cannot file a private action on my behalf, and cannot provide legal advice or evaluate claims. I further understand and agree that the contents herein may be forwarded to other appropriate state or federal agencies. The position of the Insurance Commissioner is that contents of consumer complaints and attachments are not subject to disclosure under Alabama's open records laws. There is a possibility, however, that contents and attachments may become accessible to others under the open records laws. Finally, I declare and verify that all of the above information is true and correct to the best of my knowledge.

**X**

Individual Complainant Signature (if filing individually)

Date