PBM Complaint

Request for Assistance

Attn: PBM Unit

Tracking ID:

State Use Only

Alabama Department of Insurance

Insurance Consumer Services Division

201 Monroe Street, Suite 502 | Montgomery, AL 36104

pbmcompliance@insurance.alabama.gov

Phone: (334) 241-4141

Fax: (334) 242-7562

Note:

- If you are an individual consumer filing a complaint, please use our Consumer Complaint form.
- For **PBM** Complaint(s):
  - Answer each question on this form and Email, Mail, or Fax form(s) using contact information shown above.

(PLEASE TYPE OR PRINT IN BLACK OR BLUE INK)

Section I: Complainant Information

Pharmacy Name _____ NABP/NCPDP # _____ Pharmacist/Authorized Contact _____ Title _____

Address _____ Work Phone _____

City, State, Zip _____ Cell Phone _____

Email _____ Email _____

Section II: General Information

1. Pharmacy Benefits Manager (PBM): _____
2. Health Benefit Plan provider or insurer: _____

Question 3 is for a single event. If multiple Covered Individuals (CI) with the same type of issue and the same PBM, skip #3 and use spreadsheet.

3. Name of Covered Individual (CI): _____

   a. CI id: _____ b. Date of Birth: _____ c. Rx # _____

   d. Drug Name: _____ e. Claim # _____

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4. Specific Statute or Rule in question: _____

(Check One)

5. Has the claim been appealed to the PBM? (If yes, provide PBM response) ☐ Yes ☐ No
6. Are you represented by legal counsel? ☐ Yes ☐ No
   If yes, name of Attorney: _____
7. Does your complaint involve a Self-Funded Health Benefit Plan? ☐ Yes ☐ No ☐ Unknown

Section III: PBM Problem

8. Describe your PBM Problem in Detail (use additional paper, if needed).

Provide:

- Supporting documentation for the type of problem, i.e., CoPay Clawbacks, Gag Clauses, Fees, Mail-order Pharmacies, Pharmacy of Choice, Steering, etc.
- Provide detailed Reason(s) for Complaint and SIGN below before filing.

What do you consider to be a fair resolution?

Section IV: Authorization

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

Signature - Pharmacist/Authorized Representative | Title/Position | Date

Tracking id: _____ ALDOI - PBM Complaint - Spreadsheet[1]

Use of Spreadsheet for: A) All Complaints for the same PBM B) All Complaints are for the same type of issue.

Pharmacy: _____ NABP/NCPDP # Authorized Contact: _____

Pharmacy Benefits Manager: A) _____ Specific Statute/Rule in question: B) _____

3.a-e

Count	Name of Covered Individual (CI)	a. CI id #	b. Date of Birth	c. Rx #	d. Drug Name	e. Claim #
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						

Tracking id: _ _ _ _ _ _

ALDOI- PBM Complaint- Spreadsheet[1]

Count	Name of Covered Individual(CI)	a.CI id#	b. Date of Birth	c.Rx#	d. Drug Name	e. Claim##
20.						
21.						
22.						
23.						
24.						
25.						
26.						
27.						
28.						
29.						
30.						
31.						
32.						
33.						
34.						
35.						
36.						
37.						
39.						
40.						

[1]This spreadsheet must be accompanied by a completed PBM Complaint Form.