Pharmacy Benefits Manager (PBM) Complaint Form

Email to: BOIPBMComplaints@scc.virginia.gov
Bureau of Insurance, State Corporation Commission
Toll-free: 1-877-310-6560 | Fax: 804-371-9944 | scc.virginia.gov

Please use this form to file a complaint against a PBM providing pharmacy benefits management services for commercial health plans under Virginia law. Complete only those fields relevant to your complaint, with information available to you. Complaints against a PBM servicing a Medicaid plan should be sent to the Department of Medical Assistance Services at https://contact.dmas.dmas.virginia.gov/contactforms/#/reportproblem.

1. Person Filing Complaint/Filing Status:

I am a(n): ☐ Insured/Patient ☐ Authorized Representative of Insured/Patient ☐ Pharmacist/Other

Name:_____

Address:_____

Business/Organization/Pharmacy:_____

Phone: _____ Email:_____

Provide the following information if you are not the Insured/Patient, but the Authorized Representative for the Insured/Patient. *Note: The Insured/Patient or applicable parent/legal guardian must sign this form and also complete and sign the Representative Authorization statement in section 6, unless the Insured/Patient is deceased, incapacitated or under age 18.*

Relationship to the Insured/Patient: _____

Name of Insured/Patient: _____

Insured's/Patient's Phone No.: _____ Email: _____

2. Pharmacy Benefits Manager:

Name: _____

Phone:_____Email:_____

PCN: _____ BIN:_____

Note: Insureds/Patients can find the BIN and PCN on their insurance card.

3. Health Insurance Information:

Type of Commercial Coverage: ☐ Health (Type: ☐ HMO ☐ PPO ☐ Other) ☐ Dental ☐

Insurance Company: _____ Health Plan Name/Number: _____

Policy/Certificate/ID No.: _____ Group: _____ Individual: _____

Note: If group coverage, please provide the complete name of the employer or group association.

4. Subject of Complaint (select all that apply):

☐ Advertising, promotions and representatives
☐ Any willing provider
☐ Copayments
☐ Delays in processing requests
☐ Disclosures
☐ Fees for claims adjudication
☐ Other (please specify): _____

☐ Network adequacy determinations
☐ Network
☐ Pharmacy audit
☐ Rebates
☐ Reimbursements
☐ Retaliation/penalties for exercising rights
☐ Spread pricing

5. Description of Complaint:

Please describe the basis for your complaint and the issued involved. If necessary, attach a separate sheet, along with any insurer or PBM correspondence that is related to this complaint and available to you.

6. Authorizations: Please provide the applicable authorizations that correspond to your filing status.

A. Insured/Patient

I have enclosed copies of correspondence related to this complaint. I , _____, authorize the BOI to send a copy of this form and any or all of the enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I also authorize the insurance company and/or PBM to release all related medical records to the BOI, and I authorize the BOI to release all related medical records to the insurance company and/or PBM.

_____ _____
Signature of Insured/Patient, parent or legal guardian (If I/P under 18) **Date**

B. Authorized Representative

The Insured/Patient, parent or legal guardian authorizes the BOI to discuss this complaint and share information with the Representative named in this complaint. I, _____, (Insured/Patient, parent or legal guardian), authorize the BOI to: (i) discuss this complaint with, and (ii) share medical information related to this complaint with _____. (Authorized Representative)

Note: This authorization is not necessary if the Representative is the parent or legal guardian of an Insured/Patient under 18 years of age, or if the Insured/Patient is deceased or incapacitated.

_____ _____
Signature of Insured/Patient (if I/P 18 or over), parent or legal guardian **Date**

C. Pharmacist or Other Complainant

I have enclosed copies of correspondence related to this complaint. I, _____, authorize the BOI to send a copy of this form and any or all of the enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I also authorize the BOI to obtain any other necessary information.

_____ _____
Signature of Pharmacist or Other Complainant **Date**

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