# 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**

**Pub. 06/21**