MISSISSIPPI BOARD OF PHARMACY

6360 Interstate 55 North, Suite 400 Jackson, Mississippi 39201
Office 601-899-8880 Fax 601-899-8904
sparker@mbp.ms.gov

ALL SPACES APPLICABLE MUST BE COMPLETED.

Please Type or Print in Black Ink

FOR OFFICE USE ONLY:

Complaint #: _____ Date Received: ____/___/____ Time: __:__ Received by: _____
Received Via: ( ) Fax ( ) Mail ( ) Visit to the Board ( ) Telephone ( ) Other

PBM PATIENT / PHARMACIST COMPLAINT FORM

PATIENT INFORMATION

Name of Complainant: Relationship to Patient:

Name of Patient: Patient ID#: Patient Date of Birth:

Address: City: State: Zip Code:

E-Mail Address:

Phone Number: Cell Phone Number: **SIGNATURE:**

PHARMACY INFORMATION

Pharmacy Name: License #:

Pharmacist's Name: License #:

Address:

City: State: Zip Code:

E-Mail Address:

Business Phone Number: Cell Phone Number: **SIGNATURE:**

PHARMACY BENEFIT MANAGER (PBM) INFORMATION

PBM Name: PBM Plan Code: PBM Bin #:

PBM Contact Name (If Available): PBM Contact Phone #:

Address: City: State: Zip Code:

E-Mail Address: Business Phone Number:

INSURANCE INFORMATION

Name of Insurance Provider:

Name (or Number) of Insurance Plan:

IS THIS AN ERISA PLAN? (Employee Retirement Income Security Act of 1974)

(Circle One) YES NO I DON'T KNOW

DETAILS OF COMPLAINT Please attach additional documents if applicable.

(Office Use Only) **DISPOSITION OF COMPLAINT** (Office Use Only)

IRC DATE:	**IRC MEMBERS:**	**1.**	**2.**
IRC DISPOSITION:			
FINAL DISPOSITION: **( ) No Action**	**( ) Phone, Email, Letter**	**( ) Board Hearing**	**( ) Informal Communication**