



# MISSISSIPPI

## BOARD OF PHARMACY



6360 Interstate 55 North, Suite 400      Jackson, Mississippi 39211  
 Office 601-899-8880      Fax 601-487-4414  
[pbadmin@mbp.ms.gov](mailto:pbadmin@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:	<b>SIGNATURE:</b>	

#### PHARMACY INFORMATION

Pharmacy Name:		License #:	
Pharmacist's Name:		License #:	
Address:			
City:		State:	Zip Code:
E-Mail Address:			
Business Phone Number:	Cell Phone Number:	<b>SIGNATURE:</b>	

#### PHARMACY BENEFIT MANAGER (PBM) INFORMATION

PBM Name:		PBM Plan Code:	PBM Bin #:
PBM Contact Name <small>(If Available):</small>		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

