MISSISSIPPI BOARD OF PHARMACY

6311 Ridgewood Rd., Suite E 401 Jackson, Mississippi 39211

Office: 601-899-8880 Email: pbmadmin@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