STATE USE ONLY—CASE NUMBER:

Pharmacy Benefit Market Examiner
700 W. State St., 3rd Floor
Boise, ID 83720-0043

Phone 208-334-4250
Fax 208-334-4398
Email pbm@doi.idaho.gov

PBM COMPLAINT FORM

Before Submitting a Complaint

Before filing a complaint against a Pharmacy Benefit Manager (PBM) with the Idaho Department of Insurance (the Department), we encourage that you first attempt to resolve the issue directly with the PBM. Keep records of all phone calls, written communications, and complete all levels of contractual appeals available. If the issue remains unresolved, please contact the Department for assistance. Please complete a separate form for each PBM if there are multiple complaints.

The following information is needed to act on your request.

Instructions for Filing a PBM Complaint

To file a complaint against a PBM for a legal violation, follow these steps:

- Complete this PBM Complaint Form in its entirety and
- Submit the completed PBM Complaint Form, along with any supporting documentation, to the Department by mail, fax, or email to the addresses provided above.

Supporting Documentation

Include as much relevant information as possible to assist the Department in investigating your complaint. Submit copies (not originals) of the following documents as applicable:

- Records of previous communications with the PBM related to the issue.
- Copies of documents that help verify or explain the problem.
- Copies of invoices, Maximum Allowable Cost (MAC) appeals, and PBM responses related to your complaint.

Note: Download a PDF version of this PBM Complaint Form to access the fillable sections.

Another option is to complete an online complaint via our website www.doi.idaho.gov.

Section I: Complainant Information

The following information is needed to act on your request. Questions marked * are required.

Current Date of Complaint *	

I am filing this complain as a:			
○	Pharmacist	○	Pharmacy Representative
○	Other	Please specify:	

Complainant Information			
First Name *		Last Name *	
Phone *		Fax	
Email *			

Section II: General Information

The following information is needed to act on your request. Questions marked * are required.

Pharmacy Information						
Pharmacy Name *						
NCPDP No. *			NPI No.			
Pharmacy Address *	Street					
	Street					
	City		State		Zip Code	
Preferred method of contact	☐	Email	☐	Phone	☐	Mail
	☐	Other	Please specify:			

PBM Information						
Name of PBM Company *						
PBM BIN *			PBM PCN			
PBM RX Group No.			License No.			
PBM Phone *			PBM Fax			
PBM Email						
PBM Address	Street					
	Street					
	City		State		Zip Code	

Covered Individual Information			
Patient RX ID #		Date of Birth	

Section III: Complaint Details

The following information is needed to act on your request. Questions marked * are required.

Claim Information			
Prescription (Rx) Number *		Date of Service *	
National Drug Code (NDC) *		Quantity Dispensed *	
Drug Name *			

Prescription (Rx) Number		Date of Service	
National Drug Code (NDC)		Quantity Dispensed	
Drug Name			

Prescription (Rx) Number		Date of Service	
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Prescription (Rx) Number		Date of Service	
National Drug Code (NDC)		Quantity Dispensed	
Drug Name			

Section III: Complaint Details

The following information is needed to act on your request. Questions marked * are required.

The Department assists pharmacies with concerns related to violations of the law. The following are examples of types of violations of which the Department can assist. Please select all applicable reasons for your complaint.

☐	Maximum Allowable Cost (MAC) Appeal Review, Idaho Code § § 41-349 (7) and (13)
☐	Retroactively Denied/Reduced a Claim for Reimbursement after Adjudication (Clawback), Idaho Code § 41-349 (8)
☐	Network Adequacy Requirements: Limiting Network to Affiliated Pharmacies, Idaho Code § 41-349 (11) (e) (i)
☐	Network Adequacy Requirements: Requiring Mail Order, Idaho Code § 41-349 (11) (e) (ii)
☐	Network Adequacy Requirements: Requiring In-Person Drug Administration at Affiliated Pharmacies/Providers Idaho Code § 41-349 (11) (e) (iii) (iv)
☐	90-Day Continuity for Formulary Changes, Idaho Code § 41-349 (11) (h)
☐	Dispensing Fee Review, Idaho Code § 41-349 (11) (i)
☐	Adjudication Fee Review, Idaho Code § 41-349 (11) (j)
☐	41-6603 Complaint, please best specify the provision of law related to your concern to help us identify the potential violation.
☐	Other, please describe below if your complaint does not fall into the above categories. If you are submitting a complaint outside these categories, please best specify the provision of law related to your concern to help us identify the potential violation.

Details of PBM complaint

Please describe your concern or complaint. *

Section III: Complaint Details

The following information is needed to act on your request. Questions marked * are required.

Appeals Information

Provide as many details as possible regarding any appeal processes you have engaged with the PBM.

Have you filed an appeal with the PBM?	○	YES	○	NO

Date of Appeal		Date PBM responded to appeal (if received)	

Provide the details of your appeal, along with the PBM's response

Desired Resolution

What do you consider to be a fair resolution for your complaint?

END OF FORM.