PBM Complaints (Pharmacy Submitted)

Your First Name *

Your Middle Name

Your Last Name & Designation *

Pharmacy Name *

NCPDP / NABP Number

Pharmacy Address *

Pharmacy Address (line 2 if needed)

City *

State *

Zip *

Phone (desired phone #) *
+1 (___)_____-_____

Email Address (best contact email) *

How do you prefer to be contacted? *

- ◯ Phone
- ◯ Email

Is the insured/patient aware of this complaint? *

- ◯ Yes
- ◯ No

Insured's First Name *

Insured's Middle Name

Insured's Last Name *

Insured's Address

Insured's City

Insured's Zip

Insured's Phone Number *

+1 (___)_____-_____

Insured's Email Address

Name of Insurance Company

Pharmacy Benefit Manager & Name of Network*

Insured's Member ID Number *

Prescription RxBIN *

Prescription Rx Group Number *

Prescription Rx PCN

Network Reimbursement ID (if known)

This info should be returned from the PBM with associated reimbursement information.

Prescription Rx Number *

Medication Name *

National Drug Code (NDC) *

Date Filled *

Days Supplied *

Quantity Filled *

What is the nature of your complaint? (Select all that apply) *

- ☐ **Licensure**
- ☐ **MAC List**
- ☐ **Price Appeals**
- ☐ **Pharmacy Audits**
- ☐ **Pharmacy Choice**
- ☐ **Spread Pricing**
- ☐ **Clinician-administered Drugs**
- ☐ **Mail-order Drugs**
- ☐ **Other**

Please describe the conduct of the alleged violation and attach any supporting documents.

(If known, please reference the relevant statute(s), references are not required.)

Fill out the Pharmacy Benefit Manager (PBM) complaint form and return it to the Department at doi.insurancecomplaints@nebraska.gov or mail to:

Nebraska Department of Insurance
P.O. Box 95087
Lincoln, NE 68509-5087