PBM Complaints

Your First Name *

Your Middle Name

Your Last Name *

Address

City

Zip

Date of Birth

Phone Number *

+1 (___)_______-_______

Insured's Email Address

How do you prefer to be contacted? *

- ◯ Phone
- ◯ Email

Are you the insured?

- ◯ Yes
- ◯ No

If not, is the insured/patient aware of this complaint? *

- ◯ Yes
- ◯ No

Name of Insurance Company

Pharmacy Benefit Manager *

Insured's Member ID Number *

Prescription RxBIN *

Prescription Rx Group Number *

Prescription Rx Number *

Medication Name *

What is the nature of your complaint? *

Please enter a brief description of the issue.

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