

Complaint & Grievance Form

Instructions

To file a complaint or grievance, please call 833-379-1660 or email, mail or fax this completed form to:
PharmaForce PBM

Attn: Grievance & Appeals

4300 S US Hwy, Suite 203-329

Jupiter, FL 33477

Fax: 1-866-825-0007

Email: rxgrievance@thepharmaforce.com

PharmaForce PBM has up to 30 days to investigate and resolve the complaint/grievance.

Patient Information

Patient Name _____ **Date of Birth** _____

Patient ID Number _____ **Phone** _____

Provider Information

Provider Name _____

Address (City, State, ZIP) _____

Phone _____ **Fax** _____

Complaint/Grievance Information

Date of Submission _____ **Time** (example 9:30 a.m. EST) _____

Submitter's Name _____

Submitter's contact information *(Complete if different from above)*

Phone _____ **Fax** *(Provider only)* _____

Description of Complaint/Grievance (Include all details relating to the matter in question. If applicable, include any supporting documentation)

Attachments

AOR Form

Other _____