PharmaForce™ PBM

Complaint & Grievance Form

Instructions

To file a complaint or grievance, please call 1-866-660-5441, email, mail, or fax this completed form to:
PharmaForce PBM
Attn: Grievance & Appeals Coordinator
1950 Butler Pike, STE 262
Conshohocken, PA 19428
Fax: 844-550-2506
Email: rxgrievance@thepharmaforce.com
To cancel your grievance/appeal, you can call, email, mail, or fax a letter to same address.

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** _____