

Section II: General Information

Covered Individual Information

If you have multiple Covered Individuals served by the same PBM with the same concerns, you may skip this question and **after completing the remainder of this form, add individual patient information to the linked spreadsheet.*

Patient ID #: _____ Date of Birth: _____

Rx#: _____ Drug Name: _____

Quantity Dispensed: _____ Claim #: _____

Pharmacy Information

Pharmacy Name: _____ NABP/NCPDP #: _____

Pharmacist/Authorized Contact: _____

Address City, State, Zip

Email Daytime phone number Alternate phone number

PBM Information

Name of Pharmacy Benefits Manager (PBM): _____

PBM Plan Code: _____ PBM Bin #: _____

PBM Contact Name PBM Phone Number

Address City, State, Zip

Email Address Business Phone Number

Insurance Information

*Does your complaint involve a Self-Insured Health Benefit Plan?

Yes

No

This is a required response. If self-insured, stop here. Self-Insured also called self-funded plans are not under the authority of the Alaska Division of Insurance and do not qualify for this process. Please reach out with questions (907) 269-7900.

Name of Health Insurance Company: _____

Plan Type:

Individual Plan

Group Plan

Name of group/employer (if applicable): _____

Group Contract #: _____ Policy #: _____

Rx Bin: _____ PCN #: _____

NDC #: _____ Other: _____

Did you file complaint or appeal directly with the **health insurer**?

If yes, indicate the outcome. Provide any supporting documents.

Section III: Complaint Details

The Division of Insurance assists individuals and pharmacies with concerns related to violations of law or rule. The following are types of violations DOI can review for compliance on. Please select all of the applicable reasons for your complaint below.

The related Trade Practices are enumerated below, as they correlate to possible reasons for complaint. The statute is provided here: [AS 21.36.520 Unfair trade practices \(a\) 1-11](#)

- Patient right to chose a pharmacist | (a) (1)
- Patient denied access to clinician administered drug | (a) (2)
- Interference with pharmacy or pharmacists right to in-network participation | (a) (3)
- Reimbursement to Non-Affiliated Pharmacies | (a) (4)
- Reduction in reimbursement for pharmacy services based on choice | (a) (5)
- Claim related data collection on a covered person's use for marketing | (a) (6)
- Barriers to receiving mailed or shipped drugs to a patient | (a) (7) (A) (B)
- PBM limiting information disclosed to patient pertaining to costs of pharmaceutical products | (a) (8)
- Spread Pricing | (a) (9)
- Prohibited rebate or pass through from from a pharmacy or a pharmacist in a pharmacy network to the pharmacy benefits manager (a) (10)
- Prohibited reversal and claims re-submittal (a) (11) (A-D)

A reason not shown above, may be provided below:

Details of PBM Problem

Please describe your PBM problem in detail and list events (with dates) in the order they happened.

Appeals Information

Please 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): _____

Outcome of Appeal. Please provide the details of your appeal, along with the **PBM's response**. Supporting documentation can be included in the following section.

Desired Resolution

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

Section V: Authorization

By submitting this consumer complaint, I authorize the Alaska Division of Insurance to investigate my complaint with the information provided on and with this form. The information provided on and with this form is true and correct to the best of my knowledge and belief. I fully understand that a copy of this form and any or all of the documentation provided for the investigation of this complaint may be forwarded to the involved PBM. I also understand that the facts relating to this matter may become a matter of public record pursuant to Alaska law once my file is closed.

To the best of my knowledge the above statement is correct. I authorize the Alaska Division of Insurance to review and release any information to any company, agency, or licensee involved in this matter. I authorize the health carrier to release all records (including protected health information) relating to this complaint to DOI in order to resolve this complaint. I represent that I have the proper authority to execute this release.

Signature

Title/Position

Date

The Division is unable to process complaints without complete information. Please provide complete information on this form to avoid delay.

Alaska Division of Insurance:
Consumer Services section e-mail:
consumerservices@alaska.gov
Website: insurance.alaska.gov
| P (907) 269-7900 | F (907) 269-7910