Complaint/Grievance Form

If you wish to submit a complaint or grievance, please contact the Customer Service Center at (800) 460-8988. If you do not have access to a phone, you can complete this form or write a letter that includes the information requested below. The completed form or your letter should be mailed or faxed to:

Complaint Processing
Pharmacy Services
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281

Or Fax to 888-246-1422

Please note: You must submit, in writing, comments, documents, records or other information relevant to the complaint / grievance. Your benefit plan design, including co-payments, prior authorization requirements, and formulary, are all determined by your prescription plan sponsor. If you have a comment or complaint about your benefit plan restrictions, please contact your health plan sponsor.

MEMBER INFORMATION		**PRESCRIPTION PLAN INFORMATION**
Member Name/Provider Name:		Insured Member's ID:
Address:		Group #
Birthdate:	Phone:	Plan Sponsor:
COMPLAINT / GRIEVANCE SUBMITTER'S INFORMATION		
Date and Time of Submission:		
Submitter's Name:		Submitter's Phone:
Has this been brought to the attention of Pharmacy Services employee before? ☐ Yes ☐ No If Yes, to whom?		
Nature of complaint / grievance (please state all details relating to the matter in question, including names, dates, places, etc. Attach additional sheets of supporting documentation about your complaint / grievance, if applicable):		
PROCESS DESCRIPTION		
Pharmacy Services has up to thirty (30) days to investigate, and resolve the complaint / grievance.		