PROVIDER COMPLAINT FORM

Complete and return this form to us in person, by mail or fax to 1(866) 912-2830.

PROVIDER DETAILS	
Name of provider:	
NPI #:	NABP #:
Contact person name:	
Phone number: ( ) -	Fax number: ( ) -
Address:	
Date:	E-mail:

COMPLAINT DETAILS	
Date of incident (if relevant):	Time:
Summary of complaint: *Briefly describe the reason for your complaint -state the service, drug name, dates, times, persons, places, etc. Provide exact details and use a second sheet of paper if needed. Attach copies of any letters, details or records that will support your complaint and/or request.*	

Please return your completed form and copies of any documentation to:

PharmPix
c/o Quality Department
Metro Office Park,
Building 2, Suite 500
Guaynabo, P.R. 00968

OUTCOME	
As a result of making this complaint, is there any outcome you would like? ☐ YES ☐ NO	
If yes, please provide details:	
Signature	Date

By filling out this form, you are providing us with necessary information to continually maintain our high standards. We will make every effort to respond within 30 days, whenever possible.

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2 Street 1, Suite 500 Guaynabo, PR 00968 | Tel. 787.620.0092 | Fax 1.866.912.2830 | www.pharmpix.com
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ACCREDITED
Pharmacy Benefit Management
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