

## 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:





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

## PharmPix c/o Quality Department 2 Street 1 Suite 500 Guaynabo PR 00968

DUTCOME
As a result of making this complaint, is there any outcome you would like? ☐ YES ☐ NO
f 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.

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

PharmPix c/o Quality Department 2 Street 1 Suite 500 Guaynabo PR 00968





