

South Carolina Department of Insurance 1201 Main Street Suite 1000 Columbia, SC 29201

Office of PBM Oversight

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Pharmacy Benefit Manager (PBM) Complaints Form

This complaint form is for pharmacies or interested parties to file complaints with the South Carolina Department of Insurance relating to pharmacy benefit manager (PBM) services. Please complete all fields and mail, email or fax the completed form to the address above with associated documentation.

<u>Note</u>: SC law requires pharmacies to make reasonable efforts to exhaust a PBM's internal appeal requirements prior to filing a complaint with the SCDOI. You must provide a copy of the appeal outcome with your complaint submission or explain why you have not exhausted the internal appeals process as a part of your complaint submission.

Pharmacy Name:	NCPDP#:			
Mailing Address:	Contact Email:			
Contact Person:	Phone #:			
Name of PSAO (if applicable):	Contact Email:			
Contact Person:	Phone #:			
Name of Health Plan (if known):	PCN:			
Member/Subscriber ID:BIN:				
Please Note: The SCDOI does not have regulatory authority over the following health plan types: •Self-Insured Groups •Out-of-State Plans •Federal Healthcare Programs (e.g., Medicaid, Medicare, TRICARE, Veterans Health Administration, Indian Health Services, Children's Health Insurance Program)				
Name of PBM:				
☐ CVS/Caremark ☐ Express Scripts ☐ Optu	ımRx 🗆 Other:			



Name of Medication (if applicable):		NDC#:			
RX#:	Fill Date:		Quantity Dispensed:		
Reimbursement Amount (if applicable)	:				
Date of Appeal with PBM:					
te PBM Denied Appeal (must provide copy of denial):					
Description and Details of the Company of the Company of the State section of the law that you below that you below the section of the law that you below the		olating. (refer to 201	9 SC Act No. 48 and Reg	<u>(. 69-77</u>)	
Does an attorney represent you in this If yes, we will need written authorization have your attorney co-sign this form letterhead with this form.	ation from your at		tervene in this ma		ıay
I declare that the information I have prov forwarded to the PBM (and/or other part understand that, under South Carolina's is closed (medical and personal records we Department of Insurance to pursue an in- all relevant information, documents, and	y that is the subject of Freedom of Informa will remain confident vestigation into my	of your complaint) for tion Act, this complatial). By submitting to complaint and the pa	or the investigation o hint becomes a public his form, I am autho hrty(ies) complained	f this matter record once rizing the SO	r. I e my file C
Signature of Complainant:			Date:		

***Please include copies of invoices, MAC appeals and replies from PBM with your complaint.

All proprietary information submitted or obtained during our investigation of this complaint shall be considered confidential under Regulation 69-77.II.C. and Sections 38-71-2220(C) and 30-4-40 of the Code of Laws of South Carolina, 1976, as amended.