WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Pharmacy Benefit Manager Complaint Form

File #: _____

West Virginia Code §33-51-1 et. Seq. allows the Offices of the Insurance Commissioner, hereafter OIC, to receive and review complaints for violations of the Pharmacy Auditing and Integrity Act. Using this online form is considered a formal complaint to the OIC pursuant to West Virginia Code of State Regulations Title 114 Series 99. The OIC may contact you for additional information.

Name: _____ County: _____

Address: _____

Email Address: _____ Telephone #: _____

Insured Name: _____

Member ID: _____

Group Number: _____

Plan Name: _____

BIN: _____ PCN: _____

Pharmacy Name: _____

Pharmacy NPI: _____

Pharmacy Address: _____

Pharmacy Telephone: _____

Pharmacy Email: _____

Pharmacy Benefit Manager: _____

Other Entities/Individuals Involved: _____

Drug Name: _____

Fill Date: _____

Rx Number: _____ Transaction #: _____

NDC: _____ GPI: _____

NADAC: _____ WAC: _____

Total Price Paid: _____ Patient Copay: _____

Paid Ingredient Cost: _____ Paid Dispensing Fee: _____

Quantity Dispensed: _____ Day's Supply: _____

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Concerning the alleged violation, please provide the following information: the statutory provision violated, if known, the facts and circumstances which form the basis of your complaint, the name of any individual or other entity involved, and any references to specific contract language that are relevant to the complaint. Please attach copies of any relevant correspondence, contract provisions, etc. You may attach additional pages if necessary.

Please be advised that any materials, medical records, or documents that you provide at any time in connection with your complaint will be shared with the insurance companies, adjusters, or agents against whom your complaint is filed, and their counsel. These documents may also be distributed to other parties engaged in your contested case or other matters pending before the Insurance Commissioner, including but not limited to the Office of Judges, the Board of Review, Third Party Administrator staff, the Consumer Advocate, hearing examiners, and other appropriate employees of this agency. Documents other than those that are exempt under the West Virginia Freedom of Information Act may also be released if we receive a request for the records under that Act. By signing the complaint below, you are specifically authorizing the OIC to disseminate or distribute to any party or entity described above any private information that you have filed at any time with the OIC that relates to your complaint. You further authorize such other distribution of this information as the laws of the United States and the State of West Virginia permit or require.

Signature: _____ Date: _____

Please complete, sign, date, and return the original form with any attachments to:

Life and Health Division
WV Offices of the Insurance Commissioner
Post Office Box 50540
Charleston, West Virginia 25305-0540

Telephone (304) 558-3386
Fax (304) 558-4965
OICPBM@wv.gov
www.wvinsurance.gov