Region 2 PDP Complaint Referral

Secure Fax line (212) 264-1022

Plan Name: _____

Date of Complaint _____

State _____

Is the beneficiary completely out of medication and unable to get it? _____

_____

Caller Name _____

Beneficiary Name: _____

Date of Birth _____

HICN _____

LIS Eligible _____

Call Back # _____

Preferred Call Back Time _____

Language _____

Pharmacy Name _____

Pharmacy Street Address _____

_____

_____

Pharmacy City _____

Pharmacy State _____

Pharmacy Zip _____

Pharmacy Phone _____

Plan Contract _____

Plan Member _____

PBP Number _____

Prescription Discount Drug Card? _____

Drug(s) information: _____

Reason card didn't work at pharmacy _____

_____

Complaint Summary _____

_____