Pharmacy Audit Grievance Form

(One Claim Per Form – Attach Additional Forms as Needed)

Pharmacy Information

Pharmacy Name: _____
NPI Number: _____
NABP Number: _____
Address: _____
City, State, ZIP: _____
Phone Number: _____
Fax Number (if available): _____
Contact Person Name: _____
Contact Email Address: _____

Audit Information

Auditing Entity (PBM/SIU): _____
Audit Case/File Number: _____
Date of Audit: _____
Date of Final Audit Report: _____

Claim Details – One Per Form

Rx Number: _____
Claim Number (if known): _____
Date of Service: _____
Drug Name & Strength: _____
Quantity Dispensed: _____
Prescriber Name: _____

Audit Finding (As Noted in Report)

Explain exactly what the audit report stated about this claim.

_____
_____
_____
_____

Grievance / Rebuttal Explanation

Explain why you are disputing the finding. Be specific.

_____
_____
_____
_____

Supporting Documentation Checklist

(Attach copies of applicable documents. Check all that apply.)

☐ Original Prescription
☐ Prescriber Statement or Records
☐ Signature Logs
☐ Dispensing Documentation
☐ Paid Invoice / Purchase Records
☐ Additional Notes
☐ Other: _____

Certification and Signature

I certify that the information provided in this grievance is true and accurate to the best of my knowledge.

Printed Name: _____
Title: _____
Signature: _____
Date: _____

Submission Instructions

Submit completed form(s) and attachments via one of the following:

- Email: pharmacy_audit@cap-rx.com
- Fax: Fax number listed on the Final Findings Audit Report
- Mail: **Capital Rx**
  Attention: Pharmacy Audit Department
  228 Park Ave. S., Suite 87234
  New York, NY 10003