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