



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: **Judi Rx**

Attention: Pharmacy Audit Department

228 Park Ave. S., Suite 87234

New York, NY 10003