Member Complaint Form

Instructions: Please complete this form to file a written complaint about your pharmacy benefits. Provide as much detail as possible to assist in resolving your concern. This form must be returned to Judi Rx to promptly resolve your complaint. Failure to do so may delay the processing of your request. Submit the completed form and all supporting documentation to **Judi Rx Attn: Customer Care 9450 SW Gemini Dr., 87234 Beaverton, OR 97008.**

If you have an urgent complaint or appeal because your health or well-being may be in danger, we are available to assist. Please contact Customer Care at the number provided on your ID card. Your safety is of utmost importance to us.

Member Information:

First Name	Last Name	Date of Birth (MM/DD/YYYY)
Member ID Number	Group Number	Phone Number
Street Address		City, State, Zip

Authorized Representative Information (if applicable):

First Name	Last Name	Phone Number
Street Address		City, State, Zip
Relationship to Member		

Note: If you wish to appoint an authorized representative, Judi Rx requiresthat you complete an Authorization to Use & Disclose Protected Health Information or Appointment of Representative (AOR) form (or its equivalent for Medicare members). This form is available on our website at **mycapitalrx.judi.health**, or by contacting Customer Care at the number on the member's prescription ID card.

Complaint Details:

Medication Name	Date of Incident	Pharmacy Name (if applicable)
Description of Complaint (please provide detailed information, incliding any prior attempts for resolution and your preferred resolution)		

Signatures:

Member Signature	Date
Authorized Representative Signature (if applicable)	Date

I affirm that the information provided is true and accurate to the best of my knowledge.

If you need assistance completing this form, contact Customer Care at the number on the member's prescription ID card.