

Pharmacy Complaint Form

Complete and return this form, with copies of any supporting documentation, in person, by mail, or by fax.

Fax: 1-866-912-2830

Mail: PharmPix, c/o Quality Department, 2 Street 1, Suite 500, Guaynabo, PR 00968

Pharmacy Details

Pharmacy Name:

NPI #:

NCPDP #:

Contact Person Name:

Phone Number:

Fax Number:

Address:

Date:

Email:

Complaint Details

Date of Incident (if relevant):

Time:

Summary of complaint: Briefly describe the reason for your complaint, including the service, drug name, dates, times, people, and places involved. Provide exact details and use a second sheet if needed. Attach copies of any letters or records that support your complaint and/or request.

pharmpix

pharmpix.com



ACCREDITED
Pharmacy Benefit Management

Expires: 12/01/2028

Outcome

As a result of making this complaint, is there an outcome you would like? ☐ Yes ☐ No

If yes, please provide details:

Signature

Date

By filling out this form, you are providing us with the information we need to continually maintain our high standards. We will make every effort to respond within 30 days.