TN Department of Commerce & Insurance

PBM Compliance
500 James Robertson Parkway, 10th Floor
Nashville, TN 37243
(615) 532-0413
FAX: (615) 532-7389

Pharmacy Benefit Manager Complaint Form

This complaint form is for pharmacies or other covered entities to file complaints with the Tennessee Division of Insurance related to pharmacy benefit managers (PBMs). Please complete this form and submit it by mail, email, or fax to the address below with any additional documentation related to the complaint.

I. Person Filing the Complaint

1. Your Name ____________________

Business Name ____________________ (if filing on behalf of a business)

Mailing Address ____________________

City ____________ State ____________ Zip Code ____________

Email ____________________

Phone number (Daytime) ____________________

2. I am filing this complaint as:

☐ Insured ☐ Pharmacy ☐ Other (specify) ____________

II. Insurance Policy Information

3. Name of Insurance Company (Provide the exact name of the insurance company as it appears on your medical insurance card. Incorrect names will delay the handling of your complaint.)

4. Name of Policyholder or Insured

5. Name of Member/Dependent (if different than insured)

6. Type of Insurance
☐ Individual Health Insurance ☐ Group Health Insurance

If Group, Name of Employer

7. Date Policy or Certificate was sold	8. State in which Policy or Certificate was sold

III. Pharmacy Benefit Manager Information

If you are a patient, please provide the following information from your pharmacy benefit card.

9. Name of Pharmacy Benefits Manager

10. Rx Group/GRP	11. Member/Dependent ID
12. Rx BIN	13. Rx PCN

IV. Pharmacy Claim Information

If this is related to a specific pharmacy claim or medication, provide as much of the following information as possible.

14. Name of Pharmacy	
15. Claim or File #, if applicable	16. Date of claim, transaction, or denial (as applicable)
17. Rx #	18. NDC #
19. Drug Name	20. Quantity Dispensed

V. Details of Complaint

21. Please check the issue or issues that your complaint pertains to:

Allowing Disclosures

☐ Insurer or PBM penalizing a pharmacy for (or restricting pharmacy from) disclosing a lower price available for a prescription drug by not using health insurance for prescription purchase. T.C.A. § 56-7-3114

Step Therapy

☐ Insurer or PBM failing to provide a step therapy exception. T.C.A. § 56-7-3502

Steering

☐ Insurer or PBM interfering with an insured's right to choose a contracted pharmacy. T.C.A. § 56-7-3120

Audits

☐ Insurer or PBM failing to comply with statutory requirements for audits of pharmacy/pharmacist. T.C.A. § 56-7-3103

Other

☐ Please describe below in item number 22 if your complaint does not fall into the above categories.

22. Please provide any additional information related to your complaint or a narrative of your complaint if the subject matter is not captured in the above categories. Please only include **copies/scans** of important papers (NO ORIGINALS, NO PHOTOS), letters, or other information if they relate to your complaint.

23. Please indicate what actions should be taken to resolve your complaint.

24. Have you previously reported this complaint to us or any other governmental agency?

☐ Yes ☐ No If yes, which agency and what action was taken?

VI. Submission Details

I declare that the information I have furnished is true and accurate.

Signature Date

Email: PBM.Compliance@tn.gov

Fax: 615-532-7389

Mailing Address:
Department of Commerce and Insurance
PBM Compliance
Attn: Director of PBM Enforcement
500 James Robertson Parkway, 10th Floor
Nashville, TN 37243-0574