

Medicare Part D Complaint Form for CMS Region II - New York, New Jersey, Puerto Rico & U.S. Virgin Islands

Plan Name:

Date

State

**Is the beneficiary completely out of medication
and unable to get it?**

Caller Name

Beneficiary Name

Date of Birth

HICN

LIS Eligible

Call Back #

Preferred Call Back Time

Language

Reason card didn't work at pharmacy

Complaint Summary

Pharmacy Name

Pharmacy Street Address

Pharmacy City

Pharmacy State

Pharmacy Zip

Pharmacy Phone

Plan Contract

Plan Member

PBP Number

Prescription Drug Card

Drug(s) information