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Pharmacy Solutions

Appeal – Complaint Form

This form is not to be used for a clinical prior authorization. See the form titled **Prior Authorization Appeal form** if you wish to file a prior authorization appeal.

If you wish to file an appeal to a complaint not resolved to your satisfaction, contact the Customer Service Center at (800) 460-8988. If you do not have access to a phone, you can complete this form or write a letter that includes the information requested below. The completed form or your letter should be mailed or faxed to:

Complaint Appeal Processing
Envolve Pharmacy Solutions
1850 W. Rio Salado Parkway, Suite 211
Tempe, AZ 85281

Or fax to (888) 246-1422

Please note: You must submit, in writing, comments, documents, records or other information relevant to the appeal. If you decide to appeal this complaint decision, it will have no effect on your rights to any other benefits under your plan. Your benefit plan design, including co-payments, prior authorization requirements, and formulary, are all determined by your prescription plan sponsor.

MEMBER INFORMATION		PRESCRIPTION INFORMATION
Member Name/Provider Name:		Insured Member's ID:
Address:		Group #:
Birth Date:	Phone:	Plan Sponsor:

SUBMITTER'S INFORMATION	
Date and Time of Submission:	
Submitter's Name and Title	Submitter's Phone Number:

Please check one: Standard Appeal ☐ or Expedited Appeal ☐

Compliant / Grievance: An oral or written expression of dissatisfaction.

Appeal: A request to change a complaint decision made by the organization. A member or authorized representative of a member may appeal a complaint decision.

A standard appeal is a request to change a complaint decision with no imminent or serious threat to member's health. An expedited appeal is available when the complaint decision may result in an imminent or serious threat to the member's health and:

1. Involves continued or extended health care services, procedures, or treatments; OR
2. Involves additional services for a course of continued treatment prescribed by a health care provider; OR
3. Home care following inpatient admission; OR
4. The health care provider believes an immediate appeal is warranted.

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Original Complaint Date:	Complaint Tracking Number/Date of Resolution Letter
Describe reasons for the appeal (please state all details relating to the matter in question, including names, dates, places, etc. Attach additional sheets of supporting documentation about your appeal, if applicable):	

Confidential information will be used for investigative & reporting purposes by Envolve Pharmacy Solutions staff only.