



LOUISIANA DEPARTMENT OF INSURANCE
 Office of Health Insurance
 P. O. Box 94214
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 Baton Rouge, LA 70804-9214
 (800) 259-5300 (225) 219-4770 Fax (225) 342-5711

PHARMACY PROMPT PAYMENT MULTIPLE CLAIM COMPLAINT FORM

Part I

Pharmacy Information		
Name of Pharmacy		
Address		
City	State	Zip Code
Contact Person		
Telephone Number	E-mail Address	
Complete appropriate blocks below as it applies to claim submission(s) referenced in complaint.		
<input type="checkbox"/> Contracted Pharmacy Number:	<input type="checkbox"/> Electronic Claim – PBM Name and Telephone Number if applicable:	
<input type="checkbox"/> Non-Contracted Pharmacy	<input type="checkbox"/> Non-Electronic Claim	
Complaint Against		
Insurance Company Name		Telephone Number
Address		
City	State	Zip Code

DEPARTMENT USE ONLY – THIS COMPLAINT IS BEING RETURNED FOR THE FOLLOWING REASON (S)	
<input type="checkbox"/>	Insufficient / Incomplete Information
<input type="checkbox"/>	Self-Funded Private Employer or Governmental Plan – No Jurisdiction
<input type="checkbox"/>	Not Against an Authorized Insurance Company
<input type="checkbox"/>	Contract Dispute – Please Follow Appropriate Grievance Procedures
<input type="checkbox"/>	Other:
Returned by:	Date Returned:

