DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Michigan Department of Insurance and Financial Services

DIFS is an equal opportunity employer/program.
Auxiliary aids, services and other reasonable accommodations are available upon request to the individuals with disabilities.

Visit DIFS online at: www.michigan.gov/DIFS or call DIFS toll-free at 877-999-6442

Department of Insurance and Financial Services
Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Guide to Resolving Pharmacy Benefit Manager Problems

DIFS DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

When You Have a Dispute with a Pharmacy Benefit Manager (PBM):

Use the attached form to file a complaint with the Department of Insurance and Financial Services (DIFS) if you are in a dispute with a PBM and disagree with the action taken by the PBM.

You may also file a complaint online at Michigan.gov/DIFScomplaints.

Steps to resolving your complaint against a PBM:

- Contact the PBM directly to discuss your concerns and speak with a company representative to try to find a solution.
- Explain the problem in a calm, courteous manner.
- Provide specifics regarding the disagreement, including as many related facts as you can.

If you still do not agree with the PBM, ask them to provide a written response. Ask them to list the specific rules or language in the contract or statute that support their actions.

How DIFS Can Help:

If you are still dissatisfied after contacting the PBM, contact DIFS' Office of Consumer Services to ask questions or to file a written complaint by completion of this form. You may also file a complaint online at Michigan.gov/DIFScomplaints.

Your complaint is based on the documents you submit. Be sure to include all pertinent information, such as:

- Name of the PBM involved in the dispute.
- Policy and claim numbers and name of the health insurance company.
- Details of any previous contact with the PBM regarding the matter.
- Copies of documents that help verify or explain the problem.

Always send copies. Please do not send original documents.

Once you file a complaint, DIFS will respond to your complaint by doing the following:

- Contacting the PBM to obtain a written response.
- Confirming the PBM named in your complaint is performing as required under the law.

You will receive a copy of all correspondence received during DIFS' review of your complaint as well as a letter explaining our findings.

If you have questions, disagree with our findings, or have additional information that was not included with your original complaint, you may submit the information to us for further review.

Please understand that our complaints are thoroughly reviewed; however, we may not be able to provide the exact results you desire. We hope through our complaint process we can help you understand the laws that may apply.

FIS 2394 (9/24) Department of Insurance and Financial Services

Pharmacy Benefit Manager (PBM) Complaint Form

Michigan law, including PA 11 of 2022, PA 218 of 1956, and PA 350 of 1980, as amended, authorizes the review of consumer complaints involving insurance and similar products. Completion of this form is voluntary and helps us review your complaint.

My Name and Title			Name of Pharmacy Benefit Manager
Name of Pharmacy			Name of Health Insurance Company
Address			Name of INSURED person on insurance card (Please include a copy of front and back of insurance card)
City	State	Zip Code	Date of fill (if more than one, attach separate sheet): Drug Name: Quantity Dispensed:
My Email Address (By providing your email address you consent to receive DIFS correspondence via email)			
Daytime phone number	Alternate phone number		**Type of Plan** ❑ Individual plan ❑ Group Plan Name of group/employer (if applicable) _____ Group Contract # _____ Policy # _____ Rx # _____ R x B I N _____ P C N # _____ NDC # _____ NCPDP/NABP # _____ Other _____

Reason for complaint: (Check all that apply)

- ❑ Steering
- ❑ Audit
- ❑ Fees
- ❑ Cost Sharing
- ❑ MAC Appeal
- ❑ Quantity/Refill Limitations
- ❑ Network Adequacy
- ❑ Coverage for Prescription
- ❑ Claim Reversal or Recoupment
- ❑ Disclosures to covered persons (Gag Clause)
- ❑ Other_____

Have you hired an attorney to represent you in this matter? ❑ *Yes* ❑ *No*

Have you filed a lawsuit in this matter? ❑ *Yes* ❑ *No*

Please list events in the order they happened. Attach additional pages if needed. If possible please use letter size paper (8 ½ x 11") for all attachments.

Details of my complaint:

Documentation relating to your complaint is important. This information helps us to understand details of your complaint.

*Please attach copies of letters or other documents that will help us review your complaint. This includes your **insurance cards**, records, claims, or other evidence of the PBM's violations.*

Always send copies. Never send original documents.

Desired outcome:

Please mail your complaint to:
DIFS – Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

Or fax to: 517-284-8837
Or email to:
DIFS-PBMComplaints@michigan.gov

I authorize the Department of Insurance and Financial Services (DIFS) to review and release any information, including any medical information that I have provided, to any company, agency, licensee, or individual involved in this matter. I authorize DIFS to obtain all information that DIFS believes is necessary to resolve the complaint. I also authorize the health carrier to release to DIFS all information that is relevant to this complaint and subject to my authority. I represent that I have the proper authority to execute this release.

Signature Date signed