

INSTRUCTIONS

Print legibly or type information. Be sure to sign and date at bottom. Complete **all** sections of this form.
Mail one copy of THIS FORM ONLY to the two addresses listed below.

Mail-Order Pharmacy Allegation Form

Information About You		
Your Name		
Street Address		
City		
State	Zip Code	County
Telephone Number		
Home: ()		Work: ()

Complaint Filed Against	
Mail-Order Pharmacy Name	
Street Address	
City	
State	Zip Code
Telephone Number	
()	

Check One:

Medicaid Patient Other: _____

Concerns (check all that apply):

Medication not received when expected Medication never received Medication different than ordered

Medication damaged (e.g., pills broken, liquid frozen) Quantity of medication delivered is wrong

Other (please explain): _____

Give details of your concerns (Use and attach additional sheets if necessary.)	
Medication Name:	Prescription #:
Name of Pharmacist who Assisted You with the Problem:	Pharmacy Contact Information:
Additional Comments:	

Signature: _____ **Date:** ____ / ____ / ____

Complete and mail or fax one copy of THIS FORM to the two addresses listed below.
The Treatment Data Form and the Authorization for Release of Privileged/Client Information Form should be mailed or faxed to the State of Michigan Department of Community Health only.

State of Michigan
Department of Community Health
Bureau of Health Professions
Complaint and Allegation Division
P.O. Box 30670
Lansing, Michigan 48909-8170
Fax: (517) 241-2389

Michigan Pharmacists Association
815 North Washington Avenue
Lansing, Michigan 48906-5198
Phone: (517) 484-1466
Fax: (517) 484-4893
www.michiganpharmacists.org