Patient Concerns / Grievances Form

PANTHERx® Specialty Pharmacy's staff strives to ensure quality products/services that are consistent with our philosophy. As stated in your Rights and Responsibilities, you have the right to be given appropriate and professional quality services without discrimination. You also have the right to voice your concerns, grievances, or complaints about your service without being threatened, restrained, or discriminated against.

If you are unhappy with our service or have concerns about safety and quality of care, we would like you to contact our management. You may either complete this form, call us at the number listed below or visit our website at www.pantherspecialty.com/grievance to submit your concerns. You may report concerns about safety or the quality of care to any regulatory board below without retaliatory action from PANTHERx Specialty Pharmacy by contacting:

URAC: (202) 216-9010, 8:30 AM to 5:00PM, Eastern Time
ACHC: (855) YES-ACHC (937-2242), 8:30 AM to 5:00PM, Eastern Time
Pennsylvania State Board of Pharmacy: (717) 783-7156, 8:30 AM to 5:00PM, Eastern Time

Within 5 calendar days of receiving your concern, we will notify the beneficiary by using telephone, email, fax, or letter format that the matter is under investigation. Within 14 calendar days, the organization will provide written notification to the beneficiary with the results of its investigation and response.

Mail form to: PANTHERx Specialty Pharmacy
24 Summit Park Drive
Pittsburgh, PA 15275

Thank you in advance for bringing your concern to our attention as it will assist us in our continuing effort to improve the quality of our services.

Patient's Name: ______________________ Date of Birth: __________

Description of the problem/concern/complaint (include dates, times and names, if possible):

____

Completed by (signature): ______________________ Date: __________

Relationship to patient (if applicable): ______________________

FOR OFFICE USE ONLY

Patient Address: ______________________ Patient Phone Number: __________

Patient Medicare or Health Insurance Claim Number: ______________________

Date Received: __________ By: ______________________

Follow-up by phone completed by: ______________ Date: ________ Time: ______ AM/PM

Items Discussed: ______________________

Resolution/ Action taken to resolve the complaint: ______________________

Follow-up by letter completed by: ______________ please attach copy Date completed: __________

Form completed by: ______________ Date mailed: __________ Date: __________