PRESCRIPTION DRUG PROGRAM GRIEVANCE FORM

Kansas State Employees HealthCare Plan

Directions: Use this form to file a written Grievance regarding 1) a partial or complete denial of prescription drug benefits, 2) a concern about the Prescription Drug Program's operation, or 3) a verbal or written Complaint that was not resolved to your satisfaction.

You must sign this form and attach any documents, records, questions, or comments necessary for a complete review. Send the completed and signed Grievance Form within 90-days of the benefit denial or incident occurrence to:

Division of Personnel Services Benefits Unit
Landon State Office Building
900 SW Jackson, Room 951-S
Topeka, KS 66612-1251

Reason for Writing:

- ☐ **Partial or complete denial of a prescription drug benefit**
  [Attach Explanation of Payment (EOP) or prescription drug receipt(s).]
- ☐ **Concern about the Prescription Drug Program's operation**
- ☐ **A verbal or written Complaint has not been resolved to my satisfaction**
  [Attach a copy of your written Complaint.]

Date of benefit denial or incident occurrence:

Name: _____ **ID#: 479-**_____

Address: _____

_____ _____ _____

SIGNATURE **Date Signed** **Daytime Telephone** (optional)