

# Patient Concerns Form

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, or call us at the number listed below. You may report concerns about safety or the quality of care to the West Virginia Board of Pharmacy without retaliatory action from WVU Medicine Specialty Pharmacy at: 304-558-0558 from 8:30 am to 5:00 pm, Eastern time.

Within 7 calendar days of receiving your concern, we will notify the beneficiary by letter that the matter is under investigation. If the resolution will take longer than 7 days, the acknowledgment letter will inform the patient or the patient's representative that we are actively working with to resolve the grievance and will include the current progress and the time frame for future updates.

The WVU Medicine Specialty Pharmacy team strives to ensure quality products/ services that are consistent with our philosophy. As stated in your Bill of 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.

**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.

## Mail completed form to:

WVU Medicine Specialty Pharmacy  
3040 University Ave, Suite 1400  
Morgantown, WV 26505

Patient's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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

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Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(print and sign)

Relationship to patient (if applicable): \_\_\_\_\_



## FOR OFFICE USE ONLY

Patient's Address: \_\_\_\_\_

Patient's Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Patient's ID Number: \_\_\_\_\_

Form 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: \_\_\_\_\_ Date completed: \_\_\_\_\_ Date mailed: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_



**SPECIALTY PHARMACY**

Phone: 304-285-7216

Toll Free: 1-844-988-7216

Fax: 304-598-4034