PRESCRIPTION DRUG PROGRAM GRIEVANCE FORM

Kansas State Employees HealthCare Plan

RESET

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 fonn 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)