Misuse of DEA Number Complaint Form
For Medicare Part D Patient

Doctor's Last Name ______________________________

City, State ______________________________

Source of Complaint: ______________________________

Prescription Denied by:

- ☐ Pharmacy
- ☐ Carrier

Date Denial Occurred: ______________________________

Retail Pharmacy: ______________________________

Retail Pharmacy Telephone # ______________________________

Mail Order/Internet Pharmacy: ______________________________

Insurance Company For Medicare Part D Patient: ______________________________

Location of Entity (State) ______________________________

Comments: ______________________________

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Please fax this form to David Danielson at (703) 739-9497.