

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
PRESCRIPTION DRUG WEB SITE  
COMPLAINT FORM

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 2.

Complainant Information:

Complainant Name:	
Complainant Address:	
City, State and Zip Code:	
Home Telephone:	Business Telephone (if applicable):

Pharmacy which you believe has engaged in unfair pricing:

Name:
Address:
County:
City, State and Zip Code:
Telephone Number:

Date on which you purchased or attempted to purchase medication:
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Please state why you believe the medication was unfairly priced:

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Additional Comments:

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Mail to:

Michigan Department of Community Health  
Attn: Office of Legal Affairs  
Capital View Building  
201 Townsend Street  
Lansing, Michigan 48913