**ILLINOIS** Department of Public Health
Ryan White Part B Program

# CONTRACT PHARMACY INCIDENT FORM

| Patient First Name | Patient Middle Initial | Patient Last Name |
|---|---|---|
| | | |

| Social Security Number (Leave blank if no valid SS number for client) | Date of Birth (mm/dd/yyyy) |
|---|---|
| | |

This form is used to communicate any issues or concerns you may be experiencing with the programs contracted pharmacy, CVS Specialty CareMark. Upon completing this form, you may fax or mail this document directly to the Program via fax or postal mail.

**Fax Number:** (217) 785-8013

**Mailing Address:** Illinois Department of Public Health – Ryan White Part B
525 West Jefferson Street, 1st Floor
Springfield, IL. 62761

| Incident Date | Date Received (IDPH USE ONLY) | Date Resolved (IDPH USE ONLY) |
|---|---|---|
| | | |

| Agency Name | Agency Contact |
|---|---|
| | |

**Incident Details: Please include a detailed description of the incident. Include names of persons you talked to, dates, etc. Use Additional pages if needed.**