



PBM CONTACT INFORMATION CHANGE FORM

Use this form to update the physical, mailing and statutory address contact information for the Pharmacy Benefit Manager (PBM). Any other changes for the PBM please contact the Pharmacy Benefits Manager Division for additional instructions. Direct the completed form or any questions to PBMLicensing@oid.ok.gov.

Name of PBM: _____

DBA (if applicable): _____

FEIN: _____ Oklahoma License No: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Statutory Address: _____

City: _____ State: _____ Zip: _____

Business Telephone: _____ Toll Free Number: _____

Main Email: _____ Website: _____

Company contact for PBM related inquiries: _____

Telephone: _____ Email: _____

The answers supplied therein are true and correct to the best of my knowledge and belief, and I further state that I recognize the applicable insurance laws of the State of Oklahoma and the rules and regulations of the Oklahoma Insurance Commissioner governing Pharmacy Benefit Managers.

Name

Title

Signature

Date