

840 Helena Avenue
Helena, Montana 59601
csimt.gov
csi@mt.gov
406.444.2040

APPLICATION FOR LICENSE—PHARMACY BENEFIT MANAGER

APPLICATION REQUIREMENTS

- 1 Submission of a completed application for a Montana Pharmacy Benefit Manager (PBM).
- 2 Submission of required documentation.
- 3 Submission of a nonrefundable fee of \$1,000.

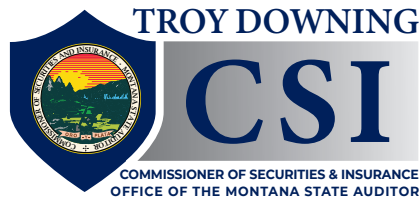
To the COMMISSIONER OF SECURITIES AND INSURANCE

1. Name of Applicant _____
(Name under which business is to be transacted and registration is to be issued.)
2. Federal Employer Identification Number (FEIN) _____
3. State of Domicile _____
4. Address of Principal Administrative Office _____
5. Telephone Number of Principal Administrative Office _____
6. Name of Principal Contact Person _____
7. Address of Principal Contact Person _____
8. Telephone Number of Principal Contact Person _____
9. E-mail Address of Principal Contact Person _____
10. Registered Name _____
(Name of the PBM or DBA (if applicable) registered with the Montana Secretary of State's office.)
11. Type of business organization registered with the Montana Secretary of State's office (select one):
Corporation LLC Partnership Other
12. Is applicant currently registered in Montana as a third-party administrator? Yes No
13. Has applicant been refused a registration, license, or certification to act as, or provide the services of, a PBM or third-party administrator, or has any registration, license, or certification to act as such been denied, suspended, revoked, or non-renewed for any reason? Yes No

If yes, attach specific details separately for each denial, suspension, etc., including the date, nature, and disposition of the action.

14. Has applicant had a business relationship with a health carrier, plan sponsor, worker's compensation carrier, or other entity that was terminated for any alleged fraudulent, illegal, or dishonest activities in connection with the administration of a pharmacy benefit plan? Yes No

If yes, attach specific details separately explaining the termination, including the date and nature of the termination.



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REQUIRED DOCUMENTATION FOR APPLICATION FOR LICENSE—PHARMACY BENEFIT MANAGER

The following materials must be submitted with the application

Proof of registration with the Montana Secretary of State's office.

The most recent fiscal year-end audited financial statement.

A list of all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state.

A projection of the number of enrollees and injured workers to be administered by the PBM in this state on an annual basis for each health carrier client, plan sponsor client, and workers' compensation insurance carrier client.

A copy of the policies and procedures demonstrating the PBM has established processes to comply with §§ 33-22-170 through 33-22-177, MCA, and § 33-22-180, MCA, concerning maximum allowable costs lists, including the appeals process required under § 33-22-173, MCA.

A list of the licensed pharmacies in the PBM network on a form prescribed by CSI.

Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary, in a pharmacy or mail-order pharmacy that is part of the PBM's network.

Disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary, by a health carrier or workers' compensation insurance carrier in the PBM or by the PBM in a health carrier or workers' compensation insurance carrier.

An NAIC biographical affidavit or resume for every individual identified in response to application item #15.