**Maine Bureau of Insurance**

**Any Willing Pharmacy Reporting Form**

**Bulletin 377**

Company Name:

1. \_\_\_\_ Place an X here if your company provided information to the Bureau of Insurance in compliance with Bulletin 377 last year and the information listed on the Bureau of Insurance website for the above-named company is correct. <https://www.maine.gov/pfr/insurance/publications/annual-reports/any-willing-pharmacy>
2. \_\_\_\_\_ Place an X here if your company does NOT provide or administer network pharmacy benefits in Maine.
3. \_\_\_\_\_ Place an X here if this is a first time filing **-or-** the company has revisions: Insurance Carriers should proceed to Section I and Network Administrators should proceed to Section II.

E-mail your response as an attachment to [Barbra.L.Garboski@maine.gov](mailto:Barbra.L.Garboski@maine.gov).

**Section I. Completed by Insurance Carriers:**

**A. Compliance Officer with Responsibility for Maine Pharmacy Operations:**

|  |  |
| --- | --- |
| Name: |  |
| Title: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Direct Phone Number: |  |
| Fax: Number |  |
| Email Address: |  |

**B. Please identify any mail order pharmacies that participate in your network.** *(copy and paste table as needed for additional participants)*

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Website: |  |

**C: Pharmacy Contracting Contact Information:**

|  |  |
| --- | --- |
| Name: |  |
| Title: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Direct Phone Number: |  |
| Fax: Number |  |
| Email Address: |  |

**D. Please identify any pharmacy benefit administrators (PBMs) that administer pharmacy benefits through your pharmacy network.** *(copy and paste table as needed for additional PBMs)*

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Website: |  |

**Section II. Completed by Network Administrators:**

**A. Compliance Officer with Responsibility for Network Pharmacy Operations in Maine:**

|  |  |
| --- | --- |
| Name: |  |
| Title: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Direct Phone Number: |  |
| Fax: Number |  |
| Email Address: |  |

**B. Please identify any mail order pharmacies that participate in your network.** *(copy and paste table as needed for additional participants)*

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Website: |  |

**C: Pharmacy Contracting Contact Information:**

|  |  |
| --- | --- |
| Name: |  |
| Title: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Direct Phone Number: |  |
| Fax: Number |  |
| Email Address: |  |

**D. Please identify any pharmacy benefit administrators (PBMs) that administer pharmacy benefits through your pharmacy network.** *(copy and paste table as needed for additional PBMs)*

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Website: |  |

**E. Please identify any insurance carriers or health plans that use your pharmacy network.** *(copy and paste table as needed for additional carriers or health plans)*

|  |  |
| --- | --- |
| Name: |  |
| Mailing Address: |  |
|  |
|  |
|  |
| Website: |  |

E-mail your response as an attachment to [Barbra.L.Garboski@maine.gov](mailto:Barbra.L.Garboski@maine.gov).