## Maine Bureau of Insurance

## Bulletin 377

## Any Willing Pharmacy Reporting Form

**Insurance Companies**

E-mail your response as a PDF attachment to Barbra.L.Garboski@maine.gov.

|  |  |
| --- | --- |
| Company Name: |  |

 Check here if your company does NOT provide or administer network pharmacy benefits in Maine.

**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 participant)*

|  |  |
| --- | --- |
| 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 participant)*

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