Pharmacy Benefit Manager (PBM) Application

1. General Information

Name of PBM Applicant			
Provide any names under which the PBM currently conducts or intends to conduct business in the state of Michigan			
Domicile State	FEIN		
Business Address (a P.O. Box is **not** an acceptable business address)			
Street		Suite	
City	State	ZIP Code	Country
Phone Number	Fax Number		
Mailing Address			
Street or P.O. Box		Suite	
City	State	ZIP Code	Country

Does the PBM hold a certificate of authority as a Third Party Administrator (TPA) in Michigan? Yes ☐ No ☐

If an application for a certificate of authority has been submitted but not yet approved, provide the date the application was submitted:

_____

2. Primary Point of Contact

Provide the contact information for a single individual employed by the PBM who is responsible for all inquiries related to this application for licensure. This individual will also be responsible for providing updated information in the event the individual is no longer able to serve as the primary point of contact.

Primary Contact Name			
Relationship to PBM		Title	
Address			
Street		Suite	
City	State	ZIP Code	Country
Phone Number	Fax Number	E-mail Address	

3. Background Information

An affirmative answer to any question below requires additional information to be attached to this application. Failure to provide the required attachments may result in the denial of this application or delay its processing.

Has the PBM or any individual responsible for the conduct of the affairs of the PBM had a PBM certificate of authority, or license, or registration suspended, denied or revoked for cause in another state? *(Provide a detailed written statement and all relevant supporting documentation issued by the regulatory authority for each individual and company for which the answer is yes.)*	☐ Yes ☐ No
Has any individual responsible for the conduct of the affairs of the PBM been convicted of a felony, or entered a plea of guilty or nolo contendere to a felony, without regard to whether adjudication was withheld? Any person responsible for the conduct of the affairs of the PBM should be listed in Section 5 of this application. *(Attach court documentation supporting each conviction.)*	☐ Yes ☐ No
Has the applicant had a business relationship with an insurance company terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of PBM services? *(Attach specific details separately.)*	☐ Yes ☐ No
Has the PBM or any individual responsible for the conduct of the affairs of the PBM ever been named or involved as a party in an administrative proceeding, including a Financial Industry Regulatory Authority (FINRA) sanction or an arbitration proceeding, regarding any professional or occupational license or registration? *(Provide a breakdown separately specifying each individual and company that the PBM answered yes for. Provide a written statement and a copy of the administrative order or other relevant legal documentation for each action.)*	☐ Yes ☐ No

4. Consent to Service

If the PBM is domiciled in a state other than Michigan, the FIS 2389 Pharmacy Benefit Manager Consent to Service form must be completed and submitted with this application.

5. Disclosure Requirements

Complete the entries below for each “individual responsible for the conduct of affairs of the pharmacy benefit manager” as that term is defined in MCL 550.817(l), including any of the following: (i) all members of the board of directors, board of trustees, executive committee, or other governing board or committee; (ii) principal officers, partners, or members, as applicable; (iii) all persons who exercise control over the affairs of the PBM; and (iv) all shareholders or members that hold directly or indirectly 10% or more of the voting stock, voting securities, or voting interest of the PBM. See also Mich Admin Code, R 500.33(2)(b). Use additional pages as necessary and attach them to this application.

Name	Title as it relates to the PBM applicant	Ownership interest of 10% or more? Yes ☐ No ☐	
Professional Qualification(s)	Date of Birth	SSN or FEIN	
Street or P.O. Box		Phone Number	
City	State	ZIP Code	Country

Name	Title as it relates to the PBM applicant	Ownership interest of 10% or more? Yes ☐ No ☐	
Professional Qualification(s)	Date of Birth	SSN or FEIN	
Street or P.O. Box		Phone Number	
City	State	ZIP Code	Country

Name	Title as it relates to the PBM applicant	Ownership interest of 10% or more? Yes ☐ No ☐	
Professional Qualification(s)	Date of Birth	SSN or FEIN	
Street or P.O. Box		Phone Number	
City	State	ZIP Code	Country

Name	Title as it relates to the PBM applicant	Ownership interest of 10% or more? Yes ☐ No ☐	
Professional Qualification(s)	Date of Birth	SSN or FEIN	
Street or P.O. Box		Phone Number	
City	State	ZIP Code	Country

6. Organizational Documents

As indicated below, attach appropriate documentation; attachments should be copies of documents that were filed with the PBM's state of domicile's regulatory agency for business filings:

a) If incorporated, Articles of Incorporation
b) If not incorporated, Articles of Organization, Partnership Agreement, Limited Liability Company Agreement, or other analogous governing document
c) Bylaws
d) Trade Name Certificate (if applicable)
e) All amendments to these documents (if applicable)

7. PBM Description

Provide a detailed description of the PBM, including:

a) All jurisdictions where the PBM has an application pending or has been registered, licensed, or otherwise certified to transact business as a PBM.
b) Services provided
c) Facilities
d) Personnel
e) A list of every health plan or carrier on behalf of which the PBM contracts with a pharmacy or a pharmacy services administration organization to provide pharmacy health services to individuals covered by the health plan or carrier.

8. PBM Financial Statements

Submit financial statements for the PBM's most recently completed fiscal year:

a) Balance Sheet (Assets, Liability, Shareholders' Equity/Surplus)
b) Income Statement
c) Notes to Financial Statements
d) Explanation of financial viability

*May provide independently audited financial statements or the FIS 2388 Pharmacy Benefit Manager Financial Statements form. The financial statements must be those of the applicant. If the financial statements or audited financial statements combine the applicant with its parent or affiliated entities, they must include a deconsolidating spreadsheet separating the applicant's balance sheet and income statement.

9. Network Adequacy Report

The PBM must complete the template network adequacy report and submit using the online SERFF portal. New applicants will need to register with SERFF. Please see the PBM Network Adequacy Toolkit for more information on this requirement.

10. PBM Compliance

Submit FIS 2395 attesting to the PBM's business practices and each ongoing contract compliance with the act and rules.

11. Verification

I verify under oath that I hold the position of an officer, director, or partner of the applicant, and I am duly authorized and directed to file this application for a PBM license. I solemnly declare, under the penalties of perjury, that the information provided above and in the attached documents is truthful, accurate, and complete.

Print Name	Title or Position
Signature	Date

12. Applicable Fee

Attach and send Form FIS 2397, a check or money order payable in U.S. Dollars to “STATE OF MICHIGAN” in the amount of $5,000.00, and the completed application to:

Department of Insurance and Financial Services
P.O. Box 30165
Lansing, MI 48909-7665

If you have any questions regarding this form, please e-mail DIFS-PBMLicensing@michigan.gov or call 877-999-6442.