NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE
Post Office Box 1689
Santa Fe, NM 87504-1689
(505) 827-4601
PBMAnnualReport@state.nm.us

PHARMACY BENEFIT MANAGER ANNUAL REPORT

YEAR: ________________

Name of PBM:	**FEIN #:**
Annual report contact Name and Title:	**Contact phone number:**
Contact e-mail:	**Principal business address:**
Home state:	**Website:**

1. Please identify all states in which PBM is currently licensed or authorized to conduct business.

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

2. The complete names and addresses of all insurers with which the PBM had a written agreement during the preceding fiscal year. The term "insurer" shall include, but is not limited to, an employer who is approved by the Superintendent as a self-funded group plan. Privately owned single employer groups do not apply.
   a. For insurers, please include:
      1. Insurance company name;
      2. NAIC code;
      3. Address;
      4. City, State, Zip;
      5. Contact Telephone Number; and
      6. Number of New Mexico residents covered by plan.
   b. For self-funded plans, please include:
      1. Employer and/or Trust name:
      2. Address;
      3. City, State, Zip;
      4. Contact Telephone Number; and,
      5. Number of New Mexico residents covered by plan.

3. For each plan administered, a provider manual.

4. For each plan administered, a sample provider contract.

5. Number of complaints filed by New Mexico pharmacies against the PBM during the 2020 calendar year.

Officers' Verification

The report must be verified by at least two (2) officers of the administrator.

Annual Report for the calendar year ending: ____________________

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement is in full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above and of its income and deductions therefrom for the period ended and have been completed in accordance with the Generally Accepted Accounting Principles according to the best of their information, knowledge and belief, respectively.

The officers of this reporting entity being duly sworn, each depose and say that the reporting entity accept no compensation that is contingent on claims experience.

The undersigned owner, partner, officer or director of the applicant hereby certifies, under penalty of perjury, that all of the information submitted in this reporting and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license revocation and may subject me and the applicant to civil or criminal penalties.

Officer 1

Title________________________________

Signature ______________________________

Printed Name ___________________________ Date ________________________________

Office 2

Title________________________________

Signature ______________________________

Printed Name ___________________________ Date ________________________________

STATE OF __________________)
) ss.

COUNTY OF ________________)

SUBSCRIBED AND SWORN to before me this _________ day of _________________, 20_______ by _________________________ and ______________________________.

____
NOTARY PUBLIC

My commission expires:

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