

**NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE
Post Office Box 1689
Santa Fe, NM 87504-1689
(505) 827-4601
PBMAAnnualReport@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.

