COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Pharmacy Audit Integrity and Transparency Act Registration Form

Please complete form and mail with check for $35.00 made payable to the "Commonwealth of Pennsylvania" to:

Pennsylvania Insurance Department
Company Licensing Division
1345 Strawberry Square
Harrisburg, PA 17120
(717) 787-2735

Type or Print Clearly

IDENTIFICATION

NOTE: Registration is required for each unique Employer Identification Number.

Employer Identification Number: -	**Select One**: ☐ Pharmacy Benefit Manager ☐ Auditing Entity

Full Legal Name of Applicant:

Mailing Address:	Street (Required)	(If applicable, include P.O. Box)	
	City	State	Zip Code
Business Address: ☐ Same as mailing address	Street (Required)	(If applicable, include P.O. Box)	
	City	**State**	Zip Code

Applicant Main Telephone Number:
( ) -

CONTACT PERSON

Full Legal Name of Contact Person:	**Title of Contact Person:**
Business Telephone Number: ( ) -	**Business Email Address:**:

SIGNATURE

____
Authorized Representative Signature

____
Authorized Representative Name (print or type)

____
Authorized Representative Title (print or type)

____________________ Date (print or type)	____________________ Payment Check No. (print or type)

Rev. 1/31/2017