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| **COMMONWEALTH OF PENNSYLVANIA****INSURANCE DEPARTMENT****Pharmacy Audit Integrity and Transparency Act Renewal Form**Please complete form and mail with check for $35.00 made payable to the “Commonwealth of Pennsylvania” to:Pennsylvania Insurance DepartmentCompany Licensing Division1345 Strawberry SquareHarrisburg, 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) |
|            \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Original Registration Date (print or type) Current Date |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Payment Check No. (print or type) |