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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 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) | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Original Registration Date (print or type) Current Date | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Payment Check No. (print or type) | | |