

**MEDICAID DRUG REBATE PROGRAM**  
**STATE AGENCY CONTACT FORM**  
**Form CMS-368**

---

**STATE AGENCY NAME**

---

**STATE MDP CONTACT** – Person must have a valid state email address.

---

NAME OF CONTACT

EMAIL ADDRESS

---

TEL: AREA PHONE NUMBER EXT.    FAX: AREA PHONE NUMBER EXT.

---

STREET ADDRESS

---

CITY

STATE

ZIP CODE

---

**STATE TECHNICAL CONTACT** – Person responsible for sending and receiving data.

---

NAME OF CONTACT

EMAIL ADDRESS

---

TEL: AREA PHONE NUMBER EXT.    FAX: AREA PHONE NUMBER EXT.

---

NAME OF FISCAL AGENT (if applicable)

---

STREET ADDRESS

---

CITY

STATE

ZIP CODE

---

**MEDICAID DRUG REBATE PROGRAM**  
**STATE AGENCY CONTACT FORM**  
**Form CMS-368**

---

**STATE AGENCY NAME**

---

**STATE POLICY CONTACT** – Person responsible for policy decisions.

---

NAME OF CONTACT

EMAIL ADDRESS

---

TEL: AREA PHONE NUMBER EXT.    FAX: AREA PHONE NUMBER EXT.

---

NAME OF FISCAL AGENT (if applicable)

---

STREET ADDRESS

---

CITY

STATE

ZIP CODE

---

**STATE REBATE CONTACT** – Person responsible for invoice and receipt of rebate payments.

---

NAME OF CONTACT

EMAIL ADDRESS

---

TEL: AREA PHONE NUMBER EXT.    FAX: AREA PHONE NUMBER EXT.

---

NAME OF FISCAL AGENT (if applicable)

---

STREET ADDRESS

---

CITY

STATE

ZIP CODE

---