MEDICAID DRUG REBATE PROGRAM

STATE AGENCY CONTACT FORM
Form CMS-368

STATE AGENCY NAME

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

NAME OF CONTACT EMAIL ADDRESS

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

AGENCY/OFFICE/CORPORATION

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.

AGENCY/OFFICE/CORPORATION

STREET ADDRESS

CITY STATE ZIP CODE

CMS-368 (Exp. 06/30/2023) / OMB No. 0938-0582

Form CMS-368 is a report of contact for the State to name the individuals involved in the Medicaid Drug Rebate Program (MDRP), and is required only in those instances where a change to the originally submitted data is necessary. When needed, the use of Form CMS-368 by the State is considered mandatory under the authority of Section 1927 of the Social Security Act. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

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.

AGENCY/OFFICE/CORPORATION

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.

AGENCY/OFFICE/CORPORATION

STREET ADDRESS

CITY STATE ZIP CODE

Verification by the State

I certify that the contact information provided on this form is accurate.

By: _____ _____
(signature) (please print name)

Date: _____

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