

Pharmacy Benefit Manager Primary Contact Information Form for Small Pharmacy Reimbursement Appeals

This form will be used to create the user profile in the Resolution Center portal.

Name of Organization:	_____
Primary Contact Name:	_____
Street Address:	_____
City:	_____
State:	_____
Zip Code:	_____
Business Telephone:	_____
Business Fax:	_____
Primary Contact Email:	_____

Questions about this form should be directed to the Small Pharmacy Reimbursement Appeals Unit:
smallpharmacyappeals@oic.wa.gov