



## MISSISSIPPI BOARD OF PHARMACY

6360 I55 North, Suite 400  
JACKSON, MS 39211  
[sparker@mbp.ms.gov](mailto:sparker@mbp.ms.gov)

Office: 601-899-8880  
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# PBM FINANCIAL STATEMENT REPORT FORM

## FINANCIAL STATEMENT REPORTING FORM & REPORTING INSTRUCTIONS.

Pursuant to Miss. Code Ann. § 73-21-157; "Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board annually by March 1 or within sixty (60) days of the end of its fiscal year if not a calendar year. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year or the immediately preceding fiscal year of the pharmacy benefit manager."

Reporting Period:  
**Annually**  
**by**  
**March 1st**  
**Or**  
**within 60 days of the**  
**end of fiscal year.**



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### PHARMACY BENEFIT MANAGER (PBM) FINANCIAL STATEMENT

~ Instructions ~

#### ⇒ MISSISSIPPI STATUTE:

**Mississippi Code 1972 § 73-21-157.** License required to do business as pharmacy benefit manager; pharmacy benefit managers to file certain financial statements with State Board of Pharmacy; time period for filing statements.

(1) Before beginning to do business as a pharmacy benefit manager, a pharmacy benefit manager shall obtain a license to do business from the board. To obtain a license, the applicant shall submit an application to the board on a form to be prescribed by the board.

(2) Each pharmacy benefit manager providing pharmacy management benefit plans in this state shall file a statement with the board **annually by March 1** or within sixty (60) days of the end of its fiscal year if not a calendar year. The statement shall be verified by at least two (2) principal officers and shall cover the preceding calendar year or the immediately preceding fiscal year of the pharmacy benefit manager.

(3) The statement shall be on forms prescribed by the board and shall include:

- (a) A financial statement of the organization, including its balance sheet and income statement for the preceding year; and
- (b) Any other information relating to the operations of the pharmacy benefit manager required by the board under this section.

However, no pharmacy benefit manager shall be required to disclose proprietary information of any kind to the board.

(4) If the pharmacy benefit manager is audited annually by an independent certified public accountant, a copy of the certified audit report shall be filed annually with the board by June 30 or within thirty (30) days of the report being final.

(5) The board may extend the time prescribed for any pharmacy benefit manager for filing annual statements or other reports or exhibits of any kind for good cause shown. However, the board shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by subsection (1) of this section. The board may waive the requirements for filing financial information for the pharmacy benefit manager if an affiliate of the pharmacy benefit manager is already required to file such information under current law with the Commissioner of Insurance and allow the pharmacy benefit manager to file a copy of documents containing such information with the board in lieu of the statement required by this section.

(6) The expense of administering this section shall be assessed annually by the board against all pharmacy benefit managers operating in this state.



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## Pharmacy Benefit Managers Filing Requirements

**THIS FILING IS A SEPARATE REQUIREMENT OF YOUR LICENSE AND DOES **NOT** RENEW YOUR PBM LICENSE.**

1. Pursuant to **Mississippi Code 1972 § 73-21-157**, Pharmacy Benefit Managers (PBM) shall submit to the Mississippi Board of Pharmacy, on or before March 1st annually, the following: An annual report for the preceding fiscal year, which must include a **BALANCE SHEET AND INCOME STATEMENT**. The annual report must contain the signatures of two officers of the PBM verifying the financial statements to be true and correct and have been prepared in accordance with United States Generally Accepted Accounting Principles (GAAP) of the specific entity / licensee.
2. **A consolidated annual report of the parent company may be filed, however, the annual report **MUST INCLUDE A BREAKOUT OF THE LICENSED PBM.****
3. A list of the names and addresses of all insurers, providers or payors with which the PBM had an agreement during the preceding fiscal year.
4. Total number of contracts with entities doing business in Mississippi;
5. A list of any acquisitions of Mississippi pharmacies or other entities completed during fiscal year.
6. Average days paid after clean claim submission (nationally as well as specific to Mississippi);
7. Average days paid after clean claim re-submission (nationally as well as specific to Mississippi);
8. Claim denial rate as a percentage of total claims (nationally as well as specific to Mississippi);
9. Total revenues / fees associated with Mississippi;
10. A completed PBM Annual Financial Report form. *(found below)*
11. **Attach documents / information requested to the form below. DO NOT FILE AN INCOMPLETE REPORT.**
12. **This report and all required attachments should be filed electronically to:**

**Attention: PBM Administrator**

[sparker@mbp.ms.gov](mailto:sparker@mbp.ms.gov)

**Cc: [pculbertson@mbp.ms.gov](mailto:pculbertson@mbp.ms.gov)**

*(Contact us for any questions you may have.)*

**THIS FILING IS A SEPARATE REQUIREMENT OF YOUR LICENSE AND DOES **NOT** RENEW YOUR PBM LICENSE.**

**NO filing fee is required with your Annual Financial Statement.**

***This completed and signed document should be the cover of your Balance Sheet and Income Statement.***



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## PHARMACY BENEFIT MANAGER (PBM) FINANCIAL REPORT

|  |                                 |
|--|---------------------------------|
| Name of PBM found on license:<br>_____ | Mississippi License #:<br>_____ |
|--|---------------------------------|

|                      |                   |
|----------------------|-------------------|
| Name of PBM Contact: | Title / Position: |
|----------------------|-------------------|

|                                    |   |                         |
|------------------------------------|---|-------------------------|
| Contact Address:<br>_____<br>_____ | Direct Phone #:<br>____-____-_____<br>Direct Cell #:<br>____-____-_____ | Contact Email:<br>_____ |
|------------------------------------|---|-------------------------|

|                                      |                   |
|--------------------------------------|-------------------|
| Name of Financial Statement Contact: | Title / Position: |
|--------------------------------------|-------------------|

|  |   |                                   |
|--|---|-----------------------------------|
| Financial Contact Address:<br>_____<br>_____ | Direct Phone #:<br>____-____-_____<br>Direct Cell #:<br>____-____-_____ | Financial Contact Email:<br>_____ |
|--|---|-----------------------------------|

|   |   |
|---|---|
| 1. Attach a list of the names and addresses of all insurers, providers or payors with which the PBM had an agreement during the preceding fiscal year.  | <input type="checkbox"/><br><b>ATTACHED</b> |
| 2. What were your total number of contracts with entities doing business in Mississippi during the previous fiscal year?                                | _____                                       |
| 3. Attach a list of acquisitions of Mississippi pharmacies or other entities completed during the preceding fiscal year.                                | <input type="checkbox"/><br><b>ATTACHED</b> |
| 4. What is the average number of days to pay after clean claim <b>submission</b> (nationally as well as specific to Mississippi)?                       | Nationally _____<br>Mississippi _____       |
| 5. What is the average number of days to pay after clean claim <b>re-submission</b> (nationally as well as specific to Mississippi)?                    | Nationally _____<br>Mississippi _____       |
| 6. What is your claim denial rate as a percentage of total claims (nationally as well as specific to Mississippi)?                                      | Nationally _____%<br>Mississippi _____%     |
| 7. What are the total revenues associated with Mississippi during the preceding fiscal year?  | \$ _____                                    |
| 8. Attach the audited annual report of the licensed PBM for the preceding fiscal year, which must include a <b>BALANCE SHEET AND INCOME STATEMENT</b> . | <input type="checkbox"/><br><b>ATTACHED</b> |



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## ATTESTATION AND VERIFICATION OF PRINCIPAL OFFICERS OF THE PBM

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF LICENSE.

The information required herein is continuing in nature and, as the individual responsible for preparing this document, we agree to furnish an update on any information in this report.

As an authorized representative of the licensee, we hereby certify under penalty of perjury, that:

All of the information submitted in this report and attachments is true and complete. We are aware that submitting false information or omitting pertinent or material information in connection with this report may be grounds for revocation of licensure or other action or penalties to be determined by the board. We understand and will comply with the laws and regulations of the State of Mississippi to which this report is hereby presented:

## THIS DOCUMENT MUST BE SIGNED BY TWO (2) PRINCIPAL OFFICERS OF THE PBM.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINCIPAL OFFICER POSITION / TITLE

\_\_\_\_\_  
DIRECT ACCESS PHONE NUMBER

\_\_\_\_\_  
ADDRESS 1

\_\_\_\_\_  
ADDRESS 2

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINCIPAL OFFICER POSITION / TITLE

\_\_\_\_\_  
DIRECT ACCESS PHONE NUMBER

\_\_\_\_\_  
ADDRESS 1

\_\_\_\_\_  
ADDRESS 2

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
DATE SIGNED