FORM C
Pharmacy Services DSHS Open Enrollment No. HHS0014137
Contact Person Information Form

Legal Name of Respondent: _____

This form provides information about the appropriate contacts in the respondent's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit**.**

Authorizes Signatory		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Primary Contact for Application:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Financial Officer:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Accounts Payable:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Primary Contract Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		
Alternate Contract Contact:		**Mailing Address (incl. street, city, county, state, & zip):**
Title:		
Phone:	Ext.	
Fax:		
E-mail:		