TEXAS Health and Human Services

Form 1344
July 2022-E

Texas Vendor Drug Program

Managed Care Resources Update Request

Date Submitted: _____

Contact Information

Name:	Area Code and Phone No.	Email Address:

General Information

Name of Managed Care Organization	Program	Name of Pharmacy Benefits Manager	PBM Effective Date

Claims Billing

BIN	PCN	Group

Pharmacy Enrollment Information

Area Code and Phone No.:	
Area Code and Fax No.:	
Email:	
Website:	

DME Enrollment Information

Area Code and Phone No.:	
Area Code and Fax No.:	
Email:	
Website:	

Call Center Information

Pharmacy	Member	Prior Authorization

Website Information

Clinical PA website:	
Pharmacy manual website:	
Pharmacy payer sheets:	
Pharmacy forms website:	

By signing below, I certify the information provided above is verifiable and accurate to the best of my knowledge.

_____ _____

Signature **Date**