State of California
Health and Human Services Agency
Department of Managed Health Care
ELECTRONIC FILING SIGNATURE VERIFICATION
DMHC 10-066 Rev: 03/26

ELECTRONIC FILING SIGNATURE VERIFICATION

Original hardcopy **MUST** be returned to: **Department of Managed Health Care**
ATTN: Office of Plan Licensing
980 9th Street, Suite 500
Sacramento, CA 95814

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Managed Health Care (DMHC) and California Health Care Service Plans, hereinafter referred to as "HCSP" and Pharmacy Benefit Managers, hereinafter referred to as "PBM".

Health Care Service Plan / Pharmacy Benefit Manager INFORMATION

HCSP/ PBM Name (legal)

HCSP License Number
933-

PBM License Number
833-

DBA (if applicable) Address

(number, street) City State ZIP Code

SIGNATORY INFORMATION

Name (First, Last)

Phone Number

Title

Email

REQUESTED ACTION:

☐ Signatory Contact
(for Electronic Execution of eFile)

SIGNATURE

Signature of Individual (original required, ***use blue ink***)

Date

The undersigned, being fully authorized to execute on behalf of the above identified health care service plan/ pharmacy benefit manager, hereby certifies under penalty of perjury pursuant to the laws of the State of California as to this Electronic Filing Signature Verification and any other electronically submitted application, amendment, material modification, or other required filing and each

exhibit and attachment thereto, that the undersigned knows the contents thereof and that the statements therein are true and correct. The undersigned agrees that all future documents filed electronically with the Department of Managed Health Care pursuant to this verification which include the typed name of the undersigned will have the same force and effect as if the undersigned had signed the document by hand and subject to this certification under penalty of perjury.

Authorized by (must be Signatory on file with DMHC for this HCSP or PBM) SIGNATURE

Date

PRINT NAME