



**PRESCRIPTION DRUG DISCOUNT PLAN (PDDP) OPERATOR
REGISTRATION PACKET
Tenn. Code Ann. §56-57-101**

APPLICATIONS SHOULD BE MAILED TO THE FOLLOWING ADDRESS:

Tennessee Department of Commerce and Insurance
Financial Affairs Section
PDDP Registration Analyst
500 James Robertson Parkway, 7th Floor
Nashville, Tennessee 37243

For questions, call 615-532-1239 or 615-741-1670

SUPPLEMENTAL DOCUMENTATION FOR THE APPLICATION MAY BE EMAILED TO:

PDDP.Registration@tn.gov

Applicant Information:

Initial Application:

Registration Renewal:

Company Information:

PDDP Company Name: _____

*D.B.A. Name(s): _____

**(If applicable, attach separate sheet if necessary)*

Company Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Is this the mailing address? Yes No If No, provide mailing address below

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Company Phone Number: _____ Fax Number: _____

Company Contact Information:

Company Contact Name: _____ Title: _____

Contact email address: _____

Registered Service of Process (SOP) Agent in the State of Tennessee

SOP Company Name: _____

SOP Address: _____

City: _____ State: _____ Zip Code: _____

SOP Contact Name: _____

In order for your registration application to be complete, please attach the following materials to this registration form:

- A sample prescription drug discount card for each type of plan offered in Tennessee.
- A copy of the operator's promotional and marketing materials that are distributed to prospective members.

- A list of drugs and drug classifications that make up the prescription drug discount plan or if the plan is open formulary, please advise in writing.
- A list of participating pharmacies and marketers.

Certification:

On behalf of the Operator, I, _____, certify that all the information contained in this registration is true and accurate and that the promotional materials for the prescription drug cards and all other items requested in this registration are included herewith. Additionally, I certify that this prescription drug discount plan and all its materials and operations comply with Tenn. Code Ann § 56-57-101 *et seq.*

Officer of Director Signature

Officer or Director Printed Name

Title

Date

Notary Public

Date

My Commission Expires: _____