DRUG REBATE INTERNET SUBSCRIBER FORM

Complete the information below to receive Medi-Cal Drug Rebate internet access for one subscription year.

Return via courier or mail to:
Xerox State Healthcare, LLC
Medi-Cal Drug Rebate Dept.
P.O. Box 13029
Sacramento, CA 95813-4029

SECTION 1 – SUBSCRIBER INFORMATION

Check the appropriate box: ☐ New Subscription ☐ Renew Subscription ☐ Information Change

☐ Password Change ☐ Subscription Cancellation

SUBSCRIBER NUMBER (for Existing Subscriptions ONLY)

LAST, FIRST NAME

ORGANIZATION NAME (abbreviate if possible)

DAYTIME PHONE - FAX NUMBER -

STREET ADDRESS (include Apt/Ste/Rm #)

MAILING/DELIVERY ADDRESS (P.O. BOX OR RURAL AND RR BOX) (leave blank if same as above)

CITY STATE ZIP + 4 CODE -

EMAIL ADDRESS

EMAIL ADDRESS (Cont'd from above if needed)

SECTION 2 – LABELER/MEDI-CAL MANUFACTURER ACCESS

List the Labeler Codes and old Medi-Cal Manufacturer Codes you need access to, and the time frame you are allowed to view data for each one. ***The Medi-Cal Manufacturer Codes were the two-digit codes used in Medi-Cal to identify the Manufacturer/Labeler with the old Medi-Cal Drug Code (5 digits) used between first quarter 1991 and fourth quarter 1996.***

Code	Beg **Qtr/Year	End **Qtr/Year

Code	Beg **Qtr/Year	End **Qtr/Year

***** Qtr = 1 through 4 to represent the quarter in the year.***

SECTION 3 – SUBSCRIBER AGREEMENT
This agreement is required for only new subscriptions.

- The subscriber must notify DHCS in writing upon any change in Labeler status (i.e. if a Labeler is no longer allowed to be accessed by the subscriber, the subscriber must notify DHCS that the Labeler be taken off their subscription).

- The subscriber acknowledges that neither DHCS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHCS.

- The subscriber agrees under penalty of perjury that all Labelers/Medi-Cal Manufacturers listed on this form are allowed to be accessed by the organization they represent. The subscriber also agrees to furnish any legal documentation proving their accessibility to these Labelers/Medi-Cal Manufacturers upon request from DHCS.

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement and also that the information provided on this form is accurate and truthful.

_____ _____
Printed Name of Signee Authorized Signature

_____ _____
Title Date

DHCS Internal Use only:

☐ Approve ☐ Disapprove

_____ _____
Signature Date