



**ARKANSAS**  
Insurance Department

**ARKANSAS INSURANCE DEPARTMENT**

**ATTN: PBM Legal Division**

1 Commerce Way  
Little Rock, AR 72202  
501-371-2820  
FAX: 501-371-2639

**Arkansas Pharmacy Benefit Manager License Surrender Form**

PBM Name, as shown on license: \_\_\_\_\_

PBM License Number: \_\_\_\_\_

PBM Contact Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

**Reason for surrender, select all which apply:**

I am voluntarily surrendering my Arkansas PBM License.

I am selling my PBM to \_\_\_\_\_, with license number \_\_\_\_\_.

I am closing my PBM.

I am not renewing my Arkansas PBM License.

Other: \_\_\_\_\_.

Please also provide a written and signed notice requesting cancellation of the license by the PBM.

The notice should be signed by a known owner, officer, or partner of the PBM.