



PBM Plus, Inc.
An Omnicare Company

PBM Plus
Benefit Change Form

Group Name: _____

Date: _____

***Group #:** _____

***Carrier:** _____

***Plan:** _____

** Required to process*

Contact: _____

Email : _____

Phone : _____

Fax: _____

Current Benefit:

Copay: _____

Retail : _____

Mail Order: _____

Benefit Max: _____

Formulary _____

Non Formulary: _____

Single Source: _____

Multi Source: _____

Brand: _____

Generic _____

Other: _____

Requested Change:

Copay: _____

Retail: _____

Mail Order: _____

Benefit Max: _____

Formulary: _____

Non Formulary _____

Single Source: _____

Multi Source: _____

Brand: _____

Generic: _____

Other: _____

Requested Date of Benefit Change: _____

Authorized Signature: _____
Name Date

PBM Plus Approval: _____
Name Date