**NYS Department of Civil Service**

**RFP No. Rx-2018-1**

**entitled**

**“Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Prescription Drug Programs”**

M/WBE Subcontracting Posting Request Form

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(Please PRINT Firm’s Name Above)

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| **INTEREST IN M/WBE SUBCONTRACTING POSTING:**  (Check box if applicable)   * Our firm is a NYS certified M/WBE interested in a subcontracting opportunity. Please add our firm’s contact information, indicated below, to the list of certified M/WBE subcontractors that have expressed interest in this Procurement. The list will be posted on the Department’s web page for this Procurement only. * The NYS M/WBE certification documentation for our firm is attached. |

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| Name of Contact at Firm |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Title  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Email Address |
| **\_\_\_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_** |
| Date |

Complete the table above and submit it to the Pharmacy Benefits Services Procurement Manager specified in RFP, Section II.A.2.b. The completed table may be emailed, faxed and/or mailed (see addresses provided in RFP, Section II.A.2.b.).