Department of Employee Trust Funds

P.O. Box 7931

Madison, WI 53707-7931

**FORM F**

**Vendor References**

**RFP ETC0049 Administrative Services for the State of Wisconsin Pharmacy Benefit Program**

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| **Proposer Company Name:** Click or tap here to enter text. |

**Instructions:** You must provide four (4) references. Of those 4 references a minimum of three (3) must be clients for which you have provided, or currently provide, services that are similar to the services requested in the RFP you are responding to, and a minimum of one (1) pharmacist at an independent pharmacy that is in your organization’s pharmacy network.

At least one client reference should be an entity with an enrollment of at least 100,000 employees.

At least one client reference should be a public sector employer group of over 50,000 employees.

At least one of the four references should be located in the State of Wisconsin. More than one reference located in the State of Wisconsin is highly encouraged but not required.

Do not list the Department as a reference.

References must be *responsive* to **the Department**’s inquiries. Proposers may be scored lower on their responses to the general and technical questionnaires or disqualified from further scoring if references do not respond to **the Department**’s requests for information about the Proposer. It is the responsibility of the Proposer to ensure reference names, addresses, telephone numbers, and e-mail addresses remain current throughout the RFP process.

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| Entity Name: Click or tap here to enter text. | | |
| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
| Dates and # of years Proposer has worked with this client. Proposer’s services offered by this reference and number of client’s employees who utilize Proposer’s services: Click or tap here to enter text. | | |

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| Entity Name: Click or tap here to enter text. | | |
| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
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| Entity Name: Click or tap here to enter text. | | |
| Contact Person Name and Title: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |
| Dates and # of years Proposer has worked with this client. Proposer’s services offered by this reference and number of client’s employees who utilize Proposer’s services Click or tap here to enter text. | | |

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| --- | --- | --- |
| Pharmacist Name and title: Click or tap here to enter text. | | |
| Pharmacy Name: Click or tap here to enter text. | | |
| Phone: Click or tap here to enter text. | Email address: Click or tap here to enter text. | |
| City: Click or tap here to enter text. | | State: Click or tap here to enter text. |

Add additional pages as necessary.