PHARMACY PROVIDER CREDENTIALING APPLICATION

GENERAL PHARMACY DEMOGRAPHIC INFORMATION:

NCPDP #:_____ NPI #:_____ STORE #:_____

CONTRACTING CHAIN CODE #:_____ CONTRACTING CHAIN NAME:_____

(if applicable) GROUP CHAIN CODE #:_____ GROUP CHAIN NAME:_____

PHARMACY PROVIDER LEGAL NAME:_____

PHARMACY PROVIDER "DBA" NAME:_____

PHYSICAL ADDRESS:_____ SUITE #:_____

CITY:_____ STATE:_____ ZIP CODE:_____

MAILING ADDRESS SAME AS PHYSICAL ADDRESS: *YES* *NO* IF NO, SEE BELOW:

MAILING ADDRESS:_____ SUITE #:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PROVIDER: TELEPHONE #(_____)-_____-_____ FAX #(_____)-_____-_____

PRIMARY CONTACT/TITLE:_____

PRIMARY CONTACT: TELEPHONE #(_____)-_____-_____ FAX #(_____)-_____-_____

PRIMARY CONTACT EMAIL:_____

OWNERSHIP:

OWNER'S NAME:_____

DATE OPENED/ACQUIRED:_____

TYPE: *INDEPENDENT* *CHAIN* *GROUP* *GOVERNMENT/FEDERAL*

*OTHER*_____

OTHER IDENTIFICATION:

*MEDICARE ID #:_____*FEDERAL TAX ID #:_____

MEDICAID ID#/STATE:_____

*STATE LICENSE #:_____ ISSUE DATE:___/___/_____ EXPIRATION DATE:___/___/_____

*DEA #:_____ *PIC STATE LICENSE #:_____

PHARMACY SERVICES:

PRIMARY PROVIDER TYPE: *RETAIL* *LONG TERM CARE* *HOME INFUSION* *HOSPICE*

CLINIC/INSTITUTION *DISPENSING PHYSICIAN* *IHS/ITU* *MAIL ORDER* *SPECIALTY*

*OTHER/SECONDARY TYPE*_____

SERVICES PROVIDED:(circle all that apply) *WALK IN/OPEN TO PUBLIC* *LONG TERM CARE*

HOME INFUSION *DELIVERY* *NON-STERIL COMPOUNDING* *STERILE COMPOUNDING*

VACCINE ADMINISTRATION *SPECIALTY DRUG THERAPY* *E-PRESCRIBING* *340-B*

DRIVE THRU WINDOW *MULTI-LINGUAL*_____ *OTHER*_____

HOURS OF OPERATION: OPEN 24 HOURS *YES* *NO*

	SUNDAY	*MONDAY*	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*	*SATURDAY*
Open							
Close							

EMERCENCY RX SERVICES: *YES* *NO* IF YES, PHONE #(_____)-_____-_____

GENERAL AND PROFESSIONAL LIABILITY COVERAGE:

INSURANCE CARRIER:_____ *POLICY #:_____

EACH OCCURRENCE LIMIT:_____ GENERAL AGGREGATE LIMIT:_____

Please be sure to attach a current copy of these documents to have your application considered.

ADDITIONAL CRITERIA AND QUESTIONS FOR CONSIDERATION:

1. Is this facility able to transmit claims electronically in accordance with NCPDP standards?
    a. Yes_____
    b. No_____
2. Is the Pharmacist-in-Charge (PIC) or Pharmacy Manager a certified pharmacist employed by this facility?
    a. Yes_____
    b. No_____
3. Is this facility compliant with applicable access standards related to the Americans with Disabilities Act of 1990 and able to accommodate individuals with physical and non-physical disabilities?
    a. Yes_____
    b. No_____
4. Has the Pharmacy Provider(s) or any of its present owners, employees, or officers ever been convicted of federal or state drug or pharmacy service-related law convictions?
    a. Yes_____
    b. No_____
5. Does the owner of this Pharmacy Provider(s) currently own any other Pharmacy Provider(s)?
    a. Yes, list the NCPDP #'s:_____
    b. No_____
6. Is the Pharmacy Provider(s) under any restrictions of practice as imposed by the State Board of Pharmacy?
    a. Yes_____
    b. No_____
7. Has the Pharmacy Provider(s) been excluded from participation from a Federal program, including but not limited to, Medicare, Medicaid, federal health care programs or federal behavioral health care programs?
    a. Yes_____
    b. No_____
8. Does the Pharmacy Provider(s) maintain a fully stocked inventory of prescription medication in order to best serve any given member's needs?
    a. Yes_____
    b. No_____
9. Does the Pharmacy Provider(s) maintain licensure requirements and stocked inventory of CII medications?
    a. Yes_____
    b. No_____

CERTIFICATION AND SIGNATURE

All information provided above, in connection with the credentialing of this facility is complete and accurate to the best of my knowledge. I understand this application does not guarantee participation in the Network. I understand Pharmacy Data Management, Inc., will use a variety of sources, including primary sources in order to verify the contents of this application and will inspect all documents from individuals and organizations having information pertaining to the operation of this facility. If any discrepancies are found with the information provided in this application, I understand that this facility and any other facilities under the same ownership, may be denied, terminated, or suspended from access to the PDMI Network. Furthermore, I certify that all application content and supporting documents submitted, whether intentionally or negligently, are authentic and not fraudulent, and that no information has been withheld. If any such misrepresentations and/or fraud is discovered, facility shall by liable under all applicable federal and state laws for such act, including but not limited to the Federal False Claims Act 31 U.S.C. §§ 3729 – 3733, civil tort laws in any and all jurisdictions in which the facility conducts business, and criminal penalty where applicable pursuant with the Office of Inspector General. I agree that PDMI, its' representatives, employees, and agents shall not be liable for any act or omission related to the evaluation or verification of the information provided.

PRINTED NAME OF AUTHORIZED AGENT:_____

TITLE OF AUTHORIZED AGENT:_____

SIGNATURE OF AUTHORIZED AGENT:_____

DATE:_____/_____/_____