

PHARMACY PROVIDER PARTICIPATION REQUEST APPLICATION

Monday to Friday AMPM pharmacy location. Saturday AMPM "We require comprehensive general liability coverage of \$1,000,000 per occurrence / \$3,000,000 annual aggregate. A				Date:	
NCPDP # OR CHAIN CODE: NPI #: LEGAL NAME: D/B/A NAME (Corporation): D/B/A NAME (Corporation): PHYSICAL ADDRESS: CITY: STATE: POSTAL ADDRESS: (If different from above) CITY: STATE: POSTAL ADDRESS: (If different from above) CITY: STATE: PHONE: FAX: FEDERAL TAX ID: STATE ISSUED FROM: STORE FEDERAL DEA #: (Attach copy of License) STORE LICENSE #:(Attach copy of License) MEDICAID #: STATE ISSUED FROM: STATE CONTROLLED SUBSTANCE #: (If PHARMACIST IN CHARGE: (Attach copy of License) INSURANCE CARRIER**: (Attach Certificate of Insurance) SOFTWARE VENDOR: Insurance) SWITCHING COMPANY: CONTACT PERSON: E-MAIL (If available): HOURS/DAYS OF SERVICE: PHARMACY WEBSITE: Monday to Friday AMPM PM Sunday AMPM PM CONTACT PERSON SUGAVITY ERSON Signarture: CONTACT PERSON					
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Pharmacy Benefit