

## 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					
CHAIN CODE:    NPI #:      LEGAL NAME:    D/B/A NAME (Corporation):      PHYSICAL ADDRESS:    CITY:      CITY:    STATE:      POSTAL ADDRESS:    (If different from above)      CITY:    STATE:      PHONE:    FAX:      FEDERAL TAX ID:    STATE TAX ID:      STORE FEDERAL DEA #: (Attach copy of License)    STORE LICENSE #:(Attach copy of License)      MEDICAID #:    STATE ISSUED FROM:      STATE CONTROLLED SUBSTANCE #: (If applicable) Attach copy of License    PHARMACIST IN CHARGE: (Attach copy of License)      INSURANCE    CARRIER**: (Attach Certificate of Insurance)    SOFTWARE VENDOR:      INSURANCE CARRIER**: (Attach Certificate of Insurance)    PHARMACY WEBSITE:    PHARMACY WEBSITE:      Monday to Friday   PM    PHARMACY WEBSITE:    " Provider most complete the Provider Certification for gard price comprehensive general liability coverage showing these levels must be attached.      Sunday   AMPM	PHARMACY NETWORK:				
D/B/A NAME (Corporation):      PHYSICAL ADDRESS:      CITY:    STATE:    ZIP:      POSTAL ADDRESS: (If different from above)      CITY:    STATE:    ZIP:      PHONE:    FAX:      FEDERAL TAX ID:    STATE 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 applicable) Attach copy of License    PHARMACIST IN CHARGE: (Attach copy of License)      INSURANCE    CARRIER**: (Attach Certificate of Insurance)    SOFTWARE VENDOR:      SWITCHING COMPANY:    CONTACT PERSON: E-MAIL (If available):      Monday to Friday    _AMPM    * Provider most comprehensive general liability coverage of statached.      Sunday    _AMPM    ** require comprehensive general liability coverage showing these levels must be attached.      Sunday    _AMPM    Statached.    ************************************			NPI #:	NPI #:	
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CITY:    STATE:    ZIP:      POSTAL ADDRESS: (If different from above)    CITY:    STATE:    ZIP:      PHONE:    FAX:    FEDERAL TAX ID:    STATE ISSUED FROM:      STORE FEDERAL DEA #: (Attach copy of License)    STORE LICENSE #:(Attach copy of License)    MEDICAID #:      STATE CONTROLLED SUBSTANCE #: (If applicable) Attach copy of License    PHARMACIST IN CHARGE: (Attach copy of Credentials)      INSURANCE CARRIER**: (Attach Certificate of Insurance)    SOFTWARE VENDOR:      SWITCHING COMPANY:    CONTACT PERSON      HOURS/DAYS OF SERVICE:    PHARMACY WEBSITE:      * Monday to Friday    _AMPM      Sunday    _AMPM      CONTACT PERSON    SIONATURE:	D/B/A NAME (Corporation):				
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NAME: CONTACT PERSON SIGNATURE:	Sunday AM	_PM			
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Pharmacy Benefit