PHARMACY PROVIDER PARTICIPATION REQUEST APPLICATION

	Date:

GENERAL INFORMATION		
PHARMACY NETWORK:		
NCPDP # OR **CHAIN CODE**:		**NPI #:**
LEGAL NAME:		
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 Credentials)

INSURANCE CARRIER**: (Attach Certificate of Insurance)		**SOFTWARE VENDOR:**
SWITCHING COMPANY:		**CONTACT PERSON:** E-MAIL (If available):
HOURS/DAYS OF SERVICE:		**PHARMACY WEBSITE:**
Monday to Friday	**_____ AM - _____PM**	* ***Provider most complete the Provider Certification for <u>each</u> pharmacy location.*** ** ***We require comprehensive general liability coverage of $1,000,000 per occurrence / $3,000,000 annual aggregate. A copy of your liability coverage showing these levels must be attached.***
Saturday	**_____ AM - _____PM**	
Sunday	**_____ AM - _____PM**	
CONTACT PERSON NAME:		
CONTACT PERSON SIGNATURE:		
DATE:		