PHARMACY CREDENTIALING FORM

Pharmacies

The following is a list of Provider's Pharmacies covered by this Agreement (if a location is not listed, then such location is not contracted to participate and will not receive reimbursement from PHARMPIX):

Name (including any D/B/A name)			
Street Address			
Phone Number		**Fax Number**	
NCPDP#		**NPI#**	
Hours of Service			
Name (including any D/B/A name)			
Street Address			
Phone Number		**Fax Number**	
NCPDP#		**NPI#**	
Hours of Service			
Name (including any D/B/A name)			
Street Address			
Phone Number		**Fax Number**	
NCPDP#		**NPI#**	
Hours of Service			

(Please attach additional list of pharmacies, if needed.)

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pharmpiX
POWERED BY ONEARK

PROVIDER CERTIFICATION*

	Today's Date:	
GENERAL INFORMATION		
NCPDP #	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.*
Saturday	**AM** - __ **PM**	••*We require comprehensive general liability coverage of $1,000,000 per occurrence I $3,000,000 annual aggregate. A copy of your liability coverage showing these levels must be attached.*
Sunday	**AM** - **PM**	

urac
ACCREDITED
Pharmacy Benefit Management
Expires 12/01/2025

(Please attach additional list of pharmacies w/ ***Identical Federal Tax ID****)*

APPLICATION SECTION

1. If you have three or more pharmacies being covered by this contract, do you have a NCPDP chain code? If yes, please list chain code(s):	Yes	No
2. Do you maintain patient profiles? If yes, are they electronic?	Yes	No
3. Do you review prescriptions dispensed for drug interactions?	Yes	No
4. Is this pharmacy equipped to submit claims electronically in the most current NCPDP format? If no, please explain:	Yes	No
5. Are you affiliated with a buying group or Co-op? If so, please list name:	Yes	No
6. Is this pharmacy affiliated with any other pharmacy or entity, which presently maintains a pharmacy agreement with PHARMPIX? If yes, please list.	Yes	No
7. Do you provide any special services or have distribution rights to any specialty medications? *If yes, please attach detail.*	Yes	No
8. Has your pharmacy or another pharmacy you have owned ever received less than satisfactory rating by the State Board of Pharmacy, ever had its license or registration suspended/revoked or any other action taken against it? *If yes, attach explanation.*	Yes	No
9. Have any of your pharmacists ever been disciplined by the State Board, the State or Federal DEA or the State Medicaid Department? *If yes, attach explanation.*	Yes	No
10. Has the pharmacy, under current ownership, or any of its currently employed pharmacists ever been the subject of a civil lawsuit or criminal prosecution for fraud, deceit, deception or a similar offense involving moral turpitude? *If yes, attach explanation.*	Yes	No
11. Has the pharmacy, under current ownership, or any of its principals ever filed for bankruptcy, reorganization, or made a general assignment in favor of creditors? *If yes, attach explanation.*	Yes	No
12. Has the Pharmacy or any of its principals or pharmacists, ever been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare,	Yes	No

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The undersigned hereby authorizes PharmPix Corp., and its designated agents to review any

Medicaid, CHAMPUS) or by the General Services Administration (GSA) from participating in any government contract/services. *If yes, attach explanation.*		
13. Has the Pharmacy ever changed names? If yes, when? *If yes, attach a list of the previous name(s):*	Yes	No
14. Has the Pharmacy ever undergone a change in ownership? If yes, when? *Please attach a list of the previous owner's name(s).*	Yes	No
15. Is the Pharmacy a Medicare Part B Provider? If yes please provide the Pharmacy's Part B Provider Number:	Yes	No

and all records that it reasonably deems necessary within its credentialing procedures. Further, the undersigned represents and warrants that any and all information provided to PharmPix Corp. in connection with its credentialing process is true, accurate and complete, and it has not failed to state any facts or provide any documents that may be material to PharmPix Corp. in connection with its credentialing process.

Potential participating pharmacies have the right to review the information obtained from any outside primary source and the right to correct erroneous information submitted by another party.

Provider Name: (Please Print)

_____

NCPDP: Date:

_____ _____

Name of owner/Authorized Agent: (Please Print)

_____

Signature:

_____

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