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Provider Enrollment Credentialing Qualifications

THIS IS ONLY AN APPLICATION FOR PARTICIPATION AND DOES NOT GUARANTEE ACCESS INTO THE NETWORK

Step One: Complete the application below. Please fill in all required fields.
Failure to submit required data may result in your enrollment being denied.

Step Two: Return your completed application to:
PHARMACYRELATIONS@PRESCRYPTIVE.COM

Step Three: Please include the following required documents with your application for consideration

* Copy of Certificate of Liability
* State Pharmacy License
* DEA Certificate
* Federal Tax ID Certificate

General Provider Information

(ALL FIELDS ARE REQUIRED)

Please only list one NCPDP number per application.

NCPDP #: **NPI #:**

Provider Legal Name:

Provider DBA Name:

Physical Pharmacy Address:

City: **State:** Choose State **Zip:** Country:

Contact Information

By Providing email address, you are giving Prescryptive Health permission to contact you via email address.

Owners Legal Name:

Phone Number:

E-mail Address:

Primary Contact

By Providing email address, you are giving Prescryptive Health permission to contact you via email address.

Primary Contact Title:

Phone Number:

E-mail Address:

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Provider Enrollment Credentialing Qualifications (cont.)

	Yes	No
Is your Facility Open to the Public?	☐	☐
Does your pharmacy have a Disaster Recover Plan?	☐	☐
Is your Facility Compliant with all access standards related to the Americans with Disabilities Act of 1990?	☐	☐
Will your Facility disclose any disciplinary actions or investigations taken against the facility IMMEDIATLEY?	☐	☐
Has your facility ever been denied a permit or pharmacy license? If so, please list reason(s) below:	☐	☐

Yes,

Has this facility ever been under any regulatory disciplinary actions by either State, Federal, Government or any other civil or legal entities? If yes, please list reason(s) below:	☐	☐

Yes,

Has this facility been excluded from participation for a Federal Program included but not limited to, Medicare, Medicaid, federal health care programs, or under any other Federal statutes? If yes, please list reason(s) below:	☐	☐

Yes,

Has the facility DEA every been suspended or revoked? If yes, please let reason(s) below:	☐	☐

Yes,

Does your facility employee any Pharmacist, Nurses, Doctors or Technicians that are currently excluded from any federal program? If yes, please let reason(s) below:	☐	☐

Yes,

Is the facility owner(s) listed on any federal exclusion or similar program? If yes, please list reason(s) below:	☐	☐

Yes,

Does the facility owner own more than one pharmacy? If so, please list other NCPDP numbers below:	☐	☐

Yes,

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Provider Enrollment Credentialing Qualifications (cont.)

Hours of Operation:

Open 24/7? ☐

Monday	to
Tuesday	to
Wednesday	to
Thursday	to
Friday	to
Saturday	to
Sunday	to

Is your pharmacy contracted for Medicaid ☐ Yes ☐ No

If yes, which states are you licensed in?

Liability Insurance Information

Insurance Carrier

Policy Effective Date

Policy Number

Policy Expiration Date

Each Occurrence Limit

General Aggregate Limit

ATTACH A CURRENT COPY OF YOUR CERTIFICATE OF LIABILITY INSURANCE

State License Information

Facility State License Number:

Issue Date:

Expiration Date:

ATTACH A CURRENT COPY OF YOUR FACILITY STATE LICENSE

DEA Certification Information

DEA Registration Number:

Issue Date:

Expiration Date:

Schedules listed on Certificate: Indicate Yes or No for each

2 ☐ Yes ☐ No 2N ☐ Yes ☐ No 3 ☐ Yes ☐ No

3N ☐ Yes ☐ No 4 ☐ Yes ☐ No 5 ☐ Yes ☐ No

ATTACH A CURRENT COPY OF YOUR DEA CERTIFICATE

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Provider Enrollment Credentialing Qualifications (cont.)

FACILITY TYPE

Check all that Apply. Please mark "P" for primary type next to the box.

- ☐ Clinic Pharmacy
- ☐ Dispensing Physician
- ☐ DME
- ☐ Home Infusion
- ☐ Long Term Care
- ☐ Indian Health Facility
- ☐ Retail
- ☐ VA Facility
- ☐ Mail Order
- ☐ Other

If facility utilized Mail Order please list all of the states in which your pharmacy is licensed to provide Mail Order Prescription services:

State	License #	Expiration Date
Choose State		
Choose State		
Choose State		
Choose State		

Check all that Apply

Services:

- ☐ Compounding
- ☐ Assisted Living
- ☐ Delivery
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Flu/Vaccines
- ☐ Hospice Open
- ☐ 24 Hours
- ☐ Specialty Drugs
- ☐ Other

Language:

- ☐ English
- ☐ Spanish
- ☐ Japanese
- ☐ Vietnamese
- ☐ Chinese
- ☐ German
- ☐ Arabic
- ☐ Armenian
- ☐ French
- ☐ Creole
- ☐ Other

All information provided above is accurate to the best of my knowledge. The undersigned represents and warrants that any and all information provided to Prescryptive Health 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 pertinent in connection with its credentialing process. I Understand Prescryptive Health will review the information obtained from any primary source and has the right to correct erroneous information submitted by another party.

Signature Authorized

Signatory Name

(Print) Authorized

Signatory Title

Date