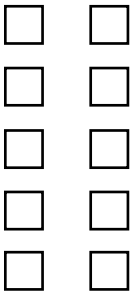
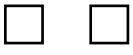
Choose State






Provider Enrollment Credentialing Qualifications cont

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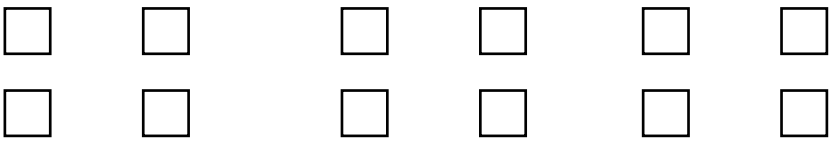

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Provider Enrollment Credentialing Qualifications (cont.)

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