Pharmacy Provider Credentialing Application

Check One: ☐New Pharmacy ☐ Change of Ownership ☐ Change of PSAO☐ Re-Credentialing

This information is required for assessing accurate information for contracted pharmacies including appropriate contractual relationship with a PSAO and for accurate reporting for regulatory agencies including CMS. This Pharmacy Application completed in its entirety by pharmacy, including any and all requested supporting documents and credential verification documents, will be used to assess and verify the qualifications of pharmacy for participation. ***Additional Credentialing may be required for Mail Delivery and to dispense specific compound or specialty products.***

General Pharmacy Information:

NCPDP #_____NPI# _____ Pharmacy DBA Name: _____

Pharmacy Legal/Corporate Name: _____Store#_____

Date Acquired (if Applicable):_____Date Opened/Expected to Open:_____

Effective Chain/PSAO affiliation Date: _____Franchised ○Yes ○No; Franchise Name:_____

Chain Code:_____Chain Name:_____

Affiliation Code:_____Affiliation Name: _____

* If Change of PSAO is selected, explain the reason for PSAO change:

_____

Pharmacy Physical Address:_____Suite#: _____City:_____

County:_____State:_____Zip: _____Phone #:_____FAX#:_____

Email Address:_____Website: _____

Credentialing Contact Information

Primary Contact:_____Primary Contact Email: _____

Pharmacy Mailing Address:_____Suite#:_____

City:_____County:_____State:_____Zip:_____

Phone #:_____FAX#:_____Email Address: _____

State License Information; DEA Certificate Information; Identification Numbers & Accreditation Information

Federal Tax ID: _____ Medicare ID #: _____Medicaid ID #: _____State:_____

State License #: _____State: _____Issue Date:_____Expiration Date: _____

Additional States Licensed:_____Full un-restricted DEA ○Yes ○No

DEA Reg. Cert. #:_____ Issue Date:_____Expiration Date: _____

Accreditation

☐URAC - Date_____Type_____☐ACHC - Date_____Type _____

☐DPA - Date_____Type_____☐TJC - Date_____Type _____

☐PCAB - Date_____Type_____☐NABP - Date_____Type _____

☐Other_____- Date_____Type _____

* *Attach a current copy of your State license and DEA Certificate along with copy(s) of* applicable non-resident licensure or registration

Pharmacy Provider Credentialing Application

Location Description:

Free Standing		Grocery Store		Strip Mall	
Medical Office		Hospital		Clinic	
Other:_____					

Please indicate approximately what percentage of the pharmacy is composed of the following services:

Retail		Specialty- Walk In		Specialty –Mail	
Mail-Order- 90 d/s		Compounding – Non-Sterile		Long Term Care	
Mail-Order- 30 d/s		Compounding – Complex/Sterile		Home Infusion	
Diabetic Supplies		DME Supplies		340B	
Physician Dispensing		Tele- Pharmacy/Remote Dispensing Site		Kiosk	
Online Pharmacy		Other: _____			

Pharmacy Operations

Hours of Operations: 24 hours: ○Yes ○No

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Does your Pharmacy provide emergency prescription services? ○Yes ○No; If yes, please provide emergency phone number: _____

Language Spoken:

Does the staff speak English? ○Yes ○No; If No List the primary language_____

Does the pharmacy have access to Language line? ○Yes ○No; If yes Provide details _____

Does the pharmacy have TTY (Text Telephone Line?) ○Yes ○No; If yes Provide information _____

Wholesaler Information: (List all wholesaler used and include additional wholesaler on a separate sheet of paper)

Wholesaler Name	NABP/DDA
	○Yes ○No
	○Yes ○No
	○Yes ○No

Wholesaler Name	NABP/DDA
	○Yes ○No
	○Yes ○No
	○Yes ○No

Does pharmacy purchase, trade, sell, or transfer drugs to or from other entities ○Yes ○No
Entities To:_____
Entities From: _____

Pharmacy Liability Insurance:

Are the store pharmacists and Technicians covered under this policy? ○Yes ○No
List all individuals coveredunder policy: _____

Has the pharmacy's malpractice coverage been denied or cancelled within the past 7 years? ○Yes ○No

Are there any employees currently employed by the pharmacy who would not be covered by the company's malpractice insurance or their own insurance policy? ○Yes ○No If Yes, please explain on separate sheet

Pharmacy Provider Credentialing Application

Pharmacy Personnel

Pharmacist in Charge:

Name:_____Date of Birth: _____ NPI # (If applicable):_____

License #_____State:_____Exp. Date: _____Date of Hire:_____

If less than 7 years, please provide the name and NCPDP of the previous pharmacy: _____

Home Address: _____

Pharmacy Personnel:

How many personnel are employed by the pharmacy? _____

Does Pharmacy use third party vendor or external staffing agency to source employees? ○Yes ○No

If yes, please provide company name and phone number: _____

Provide Legal names of all employees and any contractors

Include any pharmacy consultant/agency, Nurse, Marketing Personnel, legal representation, Pharmacist, Pharmacy Technician, Clerk, Delivery Driver, Store manager, etc. Include additional employees on a separate sheet of paper

Full Legal Name	State Lic.#	DOB	Position/Role	Education /Degree

Operational Assessment Questions:

Date of Last Full Medication Inventory:_____Date Last update reported to NCPDP: _____

Date of Last State Inspection:_____Date of Last Self Inspection: _____

1- Are you a 340B provider? ○Yes ○No, if yes

- ***a.*** Do you segregate your inventory? ○Yes ○No
- ***b.*** 340ID#:_____Entity Type:_____Start date: _____
- ***c.*** Are you owned or operated by FQHC (Federally Qualified Health Care)? ○Yes ○No

2- Is the pharmacy open-door, where prescriptions are filled for all walk-in customers without restrictions?

○Yes ○No

3- Is there a patient waiting area adjacent to where prescriptions are dispensed? ○Yes ○No; If No, please explain on separate sheet

4- Does your pharmacy have areas set aside for patient consultation? ○Yes ○No; If No, please explain on separate sheet

5- Can the pharmacy provide the majority of commercially available retail prescription drugs? ○Yes ○No; If No, please explain on separate sheet

6- Is the pharmacy limited to specific types or categories of prescription drugs? ○Yes ○No; If Yes, please explain on separate sheet

7- Does the pharmacy offer delivery service? ○Yes ○No; Approximate Delivery Range (miles): _____

If yes, do you charge a fee? ○Yes ○No; Fee amount: _____

If pharmacy delivers, does the pharmacy outsource the delivery? ○Yes ○No; who conducts the delivery?

_____

8- Does the pharmacy ship or mail prescriptions? ○Yes ○No; if yes, what %_____

If yes, do you charge a fee and postage? ○Yes ○No; if yes, fee amount: _____

9- Will the pharmacy maintain patient profiles, prescriptions, and signature logs as required by applicable State, Federal and U.S. territorial laws, and advise members that their signature acknowledges their receipt of prescriptions and allow release of any and all claims information? ○Yes ○No; If No, please explain on separate sheet

10- Will the Pharmacy disclose any disciplinary actions or investigations taken against the Pharmacy? ○Yes ○No; If No, please explain on separate sheet

11- Is the pharmacy able to participate in external audits and grievance procedures? ○Yes ○No; If No, please explain on separate sheet

12- Does the pharmacy have a policy to destroy and/or return expired medications on the shelf? ○Yes ○No; If No, please explain on separate sheet

13- Does the pharmacy routinely dispense written drug information with its prescriptions? ○Yes ○No; If Yes, attach a sample of your drug information to this application.

14- Does the pharmacy outsource pharmacist's responsibilities to another company/agency? ○Yes ○No; If Yes, please explain on separate sheet

15- Does the pharmacy have any offshore activity that involves the use of PHI (i.e. call center, claims reconciliation, marketing company/staff etc.)? ○Yes ○No; If Yes, please explain on separate sheet

16- Does the pharmacy have a current valid permit as requested by City/County/State regulatory authority to conduct business? ○Yes ○No; If No, please explain on separate sheet

17- Does the pharmacy offer direct or indirect compensation to physicians or prescribers for referrals to prescribe specific Drugs or to direct prescriptions to particular pharmacies? ○Yes ○No; If Yes, please explain on separate sheet

18- Does the pharmacy market or promote its drug services at trade shows or to payers? ○Yes ○No; If Yes, please provide sample(s)

19- Does the pharmacy market prescribers to promote its pharmacy services? ○Yes ○No; if yes, describe the employment/contractual relationship between the pharmacy and the prescribers (check all that apply):

☐ 1099 Contractors Count: _____ ☐Employees Count: _____ ☐Mixed: _____

☐Sub-contractor(s) (If so, Name:_____)

20- Does the pharmacy directly/indirectly engage with the third-party marketing firm(s) to solicit member or patient information? ○Yes ○No; If Yes, please explain on separate sheet

21- Does the pharmacy have a Code of Business/Ethics for its staff member to adhere to? ○Yes ○No; If Yes, please provide a copy

Sanctions/Exclusions/Actions

***If you answer "Yes" to any question below, please explain on a separate sheet.**

1- Has the Pharmacy, or any of its current owners, employees or officers, ever been charged with a criminal offense involving government business? ○Yes ○No

2- Has the Pharmacy, or any of its current owners, employees or officers, ever been convicted of federal or state law convictions? ○Yes ○No

3- Has the Pharmacy, or any other pharmacies under current ownership, or any of its current owners, employees or officers, ever been the subject to any regulatory or disciplinary action by either State, Federal, Government or civil entities or disciplinary action in front of the State Board of Pharmacy? ○Yes ○No

4- Has the Pharmacy, or any other pharmacies under current ownership, or any of its current owners employees or officers, ever been named in any professional liability judgements or settlements in the past 7 years? ○Yes ○No

5- Is the Pharmacy, or any of its current owners, employees or officers, under any restrictions of practice as imposed by the State Board of Pharmacy or any other governing agency? ○Yes ○No

6- Has the Pharmacy, or any other pharmacies under current ownership ever been denied, excluded, suspended or terminated by a third-party payer, prescription benefit management organization, managed care organization or other similar organization(s) within last 7 years? ○Yes ○No

7- Has the Pharmacy hired or previously hired any pharmacy personnel who were previously employed at a pharmacy terminated by a third-party payer, prescription benefit management organization, managed care organization or other similar organization(s) within last 7 years for suspected FWA? ○Yes ○No

8- Has the Pharmacy, or any other pharmacies under current ownership, or any of its current owners, employees or officers, ever been excluded from participation in any Federal program, including but not limited to: Medicare, Medicaid, federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. section 1320a-7 and other applicable federal statutes? ○Yes ○No

9- Has the Pharmacy, or any other pharmacies under current ownership or any of its current owners or officers, ever filed for bankruptcy, receivership, or reorganization? ○Yes ○No

Pharmacy Provider Credentialing Application

Pharmacy Attestation

1- OptumRx or its authorized agent, governmental agencies or their representatives, (hereafter referred to as "Auditor"), shall have the right to audit Network Pharmacy Provider during normal business hours. Network Pharmacy Provider shall cooperate with Auditors and promptly provide access to all information or documents deemed necessary by Auditors.
2- Pharmacy understands it must comply with all State/Federal/U.S. territorial regulations, including CMS rules and regulations.
3- Pharmacy understands it must have a written policy to actively review business operations and finance to minimize potential fraud waste and abuse.
4- Pharmacy understands it must have and continue to provide the necessary training to its staff to comply with all State and Federal programs.
5- Pharmacy understands waiving member copays is against the pharmacy contract and/or provider manual.
6- Pharmacy understands it must regularly monitor and provide oversight of the operations at each of its pharmacies and their pharmacists and it needs to maintain a credentialing programs for itself and its pharmacies.
7- If Pharmacy **is not** eligible to distribute Drug Products under the Public Health Service Act, Section 340(B), to the extent that Pharmacy, during the term or any renewal term of this Agreement, becomes eligible to distribute Drug Products under the Public Health Service Act, Section 340(B) program, Pharmacy shall immediately provide Administrator with written notice of such eligibility. The parties acknowledge and agree that Administrator shall be entitled to modify the rates, fees and other reimbursements offered to Pharmacy hereunder, upon Administrator's written notice to Pharmacy, to the extent that Pharmacy becomes eligible to distribute Drug Products under the Public Health Service Act, Section 340(B) program. I understand that if I fail to notify Administrator of the pharmacy's 340(B) eligibility as stated above I will be in material breach of this Agreement.
8- OptumRx may require, at its sole discretion, affiliated Network Pharmacy Providers undergoing enhanced credentialing to complete all of their credentialing information with NCPDP in lieu of Administrator's proprietary Credentialing Application. This information includes, but is not limited to, the social security numbers (SSN) and dates- of-birth of all applicable persons per the NCPDP credentialing format. I understand that I am subject to OptumRx's enhanced credentialing process at OptumRx's discretion.

Indicate your agreement and compliance with the above requirement (1-8) by initialing here _____

Required Signature

The undersigned hereby authorizes OptumRx and its designated agents to review any 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 OptumRx in connection to each of the items related to this credentialing form and 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 OptumRx in connection with its credentialing process.

The undersigned also agrees that all information provided to NCPDP is true, correct, and accurate and will be updated on an ongoing basis.

Provider Name: (Please print)_____NCPDP:_____

Name of Owner/ Authorized Agent: (Please print)_____Title:_____

Signature:_____Date: _____

OPTUMRx™ **Pharmacy Provider Credentialing Application**

Disclosure of Ownership and Control Interest Statement

Pharmacy DBA Name:_____NCPDP #: _____

Type of Entity: ☐ Sole Proprietorship; ☐ Corporation; ☐ Partnership; ☐ LLC; ☐ Other _____

1. Other than the current name, has pharmacy operated under any other trade or business name? ○Yes ○No; If yes, please provide details and name[s]: _____
2. Has your pharmacy location provided pharmacy services under a different owner and/or NCPDP # in the past seven (7) years? ○Yes ○No; If yes, please provide the previous pharmacy name, NCPDP# and pharmacy owners: _____
3. Have you had a change of ownership in the last 12 months? ○Yes ○No; Date Acquired: _____
   *Include a copy of the Bill of Sale
   a. If yes, is there a Power of Attorney (POA) in place? ○Yes ○No
      *If yes, include a copy of POA with enrollment application
   b. Did the new owner obtain a new NPI and NABP? ○Yes ○No;
      i. If yes, NCPDP:_____NPI: _____
         *If yes, include a copy of NCPDP notice which reflects effective date of new NCPDP
4. Are any of the owners of the pharmacy licensed physicians? ○Yes ○No
5. Does the pharmacy owner control pharmacy operations? ○Yes ○No; If no, please provide the name of who controls pharmacy operations _____

Ownership Structure

I. Please provide the following information for each person or entity with ownership or Control interest in the pharmacy or who is an agent or managing employee. Include additional list on a separate sheet of paper

Full Legal Name/ Entity Name	Address	DOB	SSN/TIN	% of interest	Position/Role and Degree

II. For each identified entity above, please provide the following information for each person or entity with an ownership interest in said entity. For entities with multiple layers in the organizational structure, complete additional tables until only individuals are named.

Entity Name	Full legal name/ Entity Name	Address	DOB	SSN/TIN	% of Interest	Position/ role and Degree

III. For each person or entity with an ownership interest listed on any table above, who also has ownership interest in another pharmacy, please provide the following information:

Pharmacy Name	NCPDP	Legal Entity name	TIN	%of interest

IV. Are any of the individuals identified in the sections above related to each other? ○Yes ○No; if yes, list the individuals and their relationship to each other (spouse, sibling, etc.)

Name of Owner 1	Name of Owner 2	Relationship

V. Please list any other pharmacies currently owned by family member, in full or part, or previously owned within the past seven (7) years*:

Pharmacy Name	NCPDP	Relationship and Interest Detail	Open Date

VI. List the name of any other entity (pharmacy/non-pharmacy) currently owned by a person with an ownership or controlling interest in full or part, or previously owned within the past seven (7) years*:

Name of Owner	Name of other entity (pharmacy/non-pharmacy)	Open Date

Certification and Signature

All information provided above, in connection with the credentialing of this pharmacy is complete and accurate to the best of my knowledge. I understand this application does not guarantee participation in the Network. I understand OptumRx will use a variety of sources, including primary sources, to verify the contents of this application and will inspect all documents from individuals and organizations having information pertaining to the operation of this pharmacy. If any discrepancies are found with the information provided in this application, I understand that this pharmacy and any other pharmacies under the same ownership, may be denied, terminated or suspended from access to the OptumRx Network and may be subject to an audit as outlined in 42 C.F.R. § 423.504. Furthermore, I certify that all application content and supporting documents submitted, whether intentionally or negligently, are authentic and not fraudulent, and that no information has been withheld either intentionally or negligently. If any such misrepresentations and/or fraud is discovered, facility shall by liable under all applicable federal and state laws for such act, including but not limited to the Federal False Claims Act 31 U.S.C. §§ 3729 – 3733, civil tort laws in any and all jurisdictions in which the facility conducts business, and criminal penalty where applicable pursuant with the Office of Inspector General. I agree that OptumRx, its' representatives, employees and agents shall not be liable for any act or omission related to the evaluation or verification of the information provided. I further agree to notify OptumRx immediately, of any change in the information provided.

I understand and agree that a photocopy of this authorization will be as valid as the original.

Provider Name: (Please print)_____NCPDP:_____

Name of Owner/ Authorized Agent: (Please print)_____Title:_____

Signature:_____Date: _____