



Chain/PSAO Pharmacy Network Participation Request and Credentialing Forms

Instructions:

Thank you for your interest in becoming a participating Chain/PSAO in the SelectHealth Pharmacy Network. To ensure your application is processed quickly, please complete the following. Should you have any questions, please email them to SHParmacyContracting@selecthealth.org.

1. Complete all applicable sections of the attached form.
2. Include a list of affiliated pharmacies including NABP, NPI, Pharmacy Name, Chain Code, Effective Date, and Payment Center, if applicable.
3. Include the current W-9 for the Chain/PSAO.
4. Email the completed application and affiliated pharmacies lists to SelectHealth at SHParmacyContracting@selecthealth.org.
5. Please allow for 14 business days to review your application. If approved, a contract will be faxed or emailed to you for review and signature. If denied, you will be notified.

SelectHealth Chain/PSAO Pharmacy Application

Request Date: _____

Line(s) Of Business Requested: _____

Section A: Chain/PSAO Demographics

Corporate Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Corporate Contact Name: _____

Phone: _____ Fax: _____

Email Address: _____

Complete for each affiliated Chain Code. Include additional sheets if needed.

Chain #1

Chain Name: _____

Chain Code: _____ Chain Tax ID: _____

Chain Physical Address: _____

City: _____ State: _____ Zip: _____

Chain Mailing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Name: _____

Payment Center: _____ Payment Center Tax ID: _____

Payment Center Billing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Mailing Address: _____

City: _____ State: _____ Zip: _____

Chain #2

Chain Name: _____

Chain Code: _____ Chain Tax ID: _____

Chain Physical Address: _____

City: _____ State: _____ Zip: _____

Chain Mailing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Name: _____

Payment Center: _____ Payment Center Tax ID: _____

Payment Center Billing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Mailing Address: _____

City: _____ State: _____ Zip: _____

Chain #3

Chain Name: _____

Chain Code: _____ Chain Tax ID: _____

Chain Physical Address: _____

City: _____ State: _____ Zip: _____

Chain Mailing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Name: _____

Payment Center: _____ Payment Center Tax ID: _____

Payment Center Billing Address: _____

City: _____ State: _____ Zip: _____

Payment Center Mailing Address: _____

City: _____ State: _____ Zip: _____

Affiliated Pharmacy Type(s):

Please indicate any that apply.

Retail ☐

Home Infusion ☐

Long Term Care ☐

Compounding ☐

Specialty ☐

Other:

Please Specify

Mail Order ☐

Pharmacy Claim Analysis:

Please indicate below what percentage of claims are dispensed for the following:

Retail %

Home Infusion %

Long Term Care %

Compounding %

Specialty %

Other: %

Please Specify

Mail Order %

1. Is the Chain/PSAO currently operating?

☐☐

Yes

No

If No, expected begin date:

2. Are all affiliated pharmacies in a free-standing building or retail store front, easily accessible to the general public?

☐☐

Yes

No

3. Do all affiliated pharmacies have permanent business signs on or in front of the building indicating the presence of the pharmacy?

☐☐

Yes

No

4. Do all affiliated pharmacies have information posted on the door, including name and hours?

☐☐

Yes

No

5. Other than the current name(s) listed above, has any listed Chain/PSAO operated under any other business or legal name?

☐☐

Yes

No

If Yes, please include details:

Section B: Pharmacy Policies and Procedures

1. Do all affiliated pharmacies provide services to all patients, and not just to patients with specific clinical conditions?

☐☐

Yes

No

2. Do any affiliated pharmacies provide compounding services?

☐

Yes

☐

No

If Yes, please indicate these on your pharmacy affiliation lists.

3. Do any affiliated pharmacies operate mainly as a specialty pharmacy?

☐

Yes

☐

No

If Yes, please indicate these on your pharmacy affiliation lists.

Section D: Attestation

I attest that the undersigned entity reviews the OIG and GSA exclusion lists, to ensure that no pharmacy, employee or manager responsible for the administration or delivery of Medicare benefits has been excluded from participation in Federal health care programs. If an employee is identified as being on any such lists, the employee will immediately be removed from any work related, directly or indirectly, to all Federal health care programs.

☐

Yes

☐

No

Initials

I attest that the undersigned entity has policies and procedures in place to address compliance issues associated with the CMS rules, regulations and guidance.

☐

Yes

☐

No

Initials

Section K: Signatures

Signature of Authorized Pharmacy Representative

I certify, that any, and all information provided to each item in this credentialing form and in connection with the 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 SelectHealth in connection with its credentialing process. Failure to provide true, accurate and complete information in this credentialing application may result in sanctions, up to and including denial to participate and/or termination from all SelectHealth networks.

Signature: _____

Print Name: _____

Date: _____