



Independent Pharmacy Network Participation Request and Credentialing Forms

Instructions:

Thank you for your interest in becoming a participating pharmacy in the SelectHealth Pharmacy Network. To ensure your application is processed quickly, please complete this form in its entirety, ensuring that all documents listed below are attached and legible. Should you have any questions, please email them to SHParmacyContracting@selecthealth.org.

1. Complete all applicable sections of the attached form.
2. Attach copies of the following documents with your completed application:
 - a. Current State License for the pharmacy
 - b. Current State License for the Pharmacist in Charge
 - c. Current Federal DEA License
 - d. Current Pharmacy malpractice liability insurance policy. (\$1 million claim/\$3million per occurrence)
 - e. Current W-9 for the pharmacy
 - f. Pictures where requests in the application.
3. Email the completed application to SelectHealth at SHParmacyContracting@selecthealth.org.
4. 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 Independent Pharmacy Application

Request Date: _____

Line(s) Of Business Requested: _____

Section A: Pharmacy Demographics

NCPDP/NABP #: _____ NPI: _____

Legal Name: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Pharmacy Type:

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 you dispense for the following:

Retail _____ %

Home Infusion _____ %

Long Term Care _____ %

Compounding _____ %

Specialty _____ %

Other: _____ %

Please Specify

Mail Order _____ %

1. Is the pharmacy currently open for business?

☐☐

Yes

No

If No, expected open date: _____

2. Is the pharmacy currently affiliated with a chain or PSAO through NCPDP?

☐☐

Yes

No

If Yes, name the affiliation: _____

3.	Is the pharmacy currently participating in a Franchise?	☐	☐
	Yes No		
	If Yes, what franchise: _____		
4.	Is the pharmacy in a free-standing building or retail store front, easily accessible to the general public?	☐	☐
	Yes No		
	<i>Please provide photos.</i>		
5.	Is the pharmacy located in a hospital or other type of facility that limits the pharmacy to only bill for patients of the facility?	☐	☐
	Yes No		
6.	Does the pharmacy have permanent business signs on or in front of the building indicated the presence of the pharmacy?	☐	☐
	Yes No		
	<i>Please provide photos.</i>		
7.	Does the pharmacy have its information posted on the door, including name and hours?	☐	☐
	Yes No		
	<i>Please provide photos.</i>		
8.	Is the pharmacy open 24 hours?	☐	☐
	Yes No		
	If No, indicate hours below:		
	Monday	_____ am	to _____ pm
	Tuesday	_____ am	to _____ pm
	Wednesday	_____ am	to _____ pm
	Thursday	_____ am	to _____ pm
	Friday	_____ am	to _____ pm
	Saturday	_____ am	to _____ pm
	Sunday	_____ am	to _____ pm
9.	Does the pharmacy have a patient consultation area?	☐	☐
	Yes No		
	☐ Private ☐ Semi Private		
	<i>Please provide photos of the consultation area.</i>		
10.	Does the pharmacy have a website?	☐	☐
	Yes No		
	If Yes, what is the website address: _____		
11.	Does the pharmacy provide mail order services to patients outside of the state the pharmacy is located?	☐	☐
	Yes No		

12. Does the pharmacy offer delivery of medications?

☐

Yes

☐

No

If Yes, what geographical area does the delivery include? _____

And, if Yes, what is the cost of delivery for the patient? _____

13. Does the pharmacy conduct vaccination/immunization administration services?

☐

Yes

☐

No

Please provide a brief description of the pharmacy including services offered to the community and types of prescription drugs regularly stocked in the pharmacy.

Section B: Pharmacy Ownership

Owner Name: _____

Dates of Ownership: _____

to _____

Email Address: _____

Please list any other pharmacies where you are a current owner, or a family member currently is an owner, fully or in part, or have previously been an owner in the past seven (7) years:

1. Other than the current name listed above, has the pharmacy operated under any other business or legal name?

☐

Yes

☐

No

If Yes, please include details: _____

2. Has the pharmacy location provided services under a different owner and/or NCPDP # in the past seven (7) years?	<input style="width: 40px; height: 20px;" type="checkbox"/>	<input style="width: 40px; height: 20px;" type="checkbox"/>
Yes No If Yes, provide pharmacy name, NCPDP # and owners: _____ _____ _____		
3. Are any owners of the pharmacy also licensed as a physician/prescriber?	<input style="width: 40px; height: 20px;" type="checkbox"/>	<input style="width: 40px; height: 20px;" type="checkbox"/>
Yes No If Yes, please include details: _____ _____		

Section C: Pharmacy Credentialing and Insurance Coverage

Pharmacy Licensing:

Pharmacy State Tax ID: _____	Pharmacy Federal Tax ID: _____
Pharmacy State License #: _____	Pharmacy State License Exp Date: _____
Pharmacy DEA #: _____	Pharmacy DEA Exp Date: _____

1. Is the DEA license restricted?	<input style="width: 40px; height: 20px;" type="checkbox"/>	<input style="width: 40px; height: 20px;" type="checkbox"/>
Yes No		
2. What is the most recent date that the pharmacy was inspected by the State Board of Pharmacy? Date: _____		
3. Is the pharmacy currently in good standing with State Board of Pharmacy and/or other Federal or State licensing authorities?	<input style="width: 40px; height: 20px;" type="checkbox"/>	<input style="width: 40px; height: 20px;" type="checkbox"/>
Yes No If No, please explain: _____ _____		
4. Are you, as the owner, or the pharmacy under any restriction of practice imposed by any State Board of Pharmacy?	<input style="width: 40px; height: 20px;" type="checkbox"/>	<input style="width: 40px; height: 20px;" type="checkbox"/>
Yes No If Yes, please explain: _____ _____		

5.	Does the pharmacy comply with all State, Federal and US Territorial laws and regulations including CMS rules and regulations?	☐	☐
		Yes	No
6.	Has the pharmacy previously been suspended, terminated or excluded from a PSAO network in the last five (5) years?	☐	☐
		Yes	No
	If Yes, please explain: _____		

7.	Has the pharmacy previously been suspended, terminated, or excluded from any Pharmacy Benefit Management (PBM) network in the last five (5) years for cause?	☐	☐
		Yes	No
	If Yes, please explain: _____		

8.	Has the pharmacy or Pharmacist in Charge ever been denied a license or permit or had its license or permit suspended, revoked, or been fined or had any other disciplinary action taken by a State Board of Pharmacy or other Federal or State licensing or regulatory authorities?	☐	☐
		Yes	No
	If Yes, please explain: _____		

9.	Has the pharmacy or any of its present owners, officers, or employees ever been convicted of any State or Federal law?	☐	☐
		Yes	No
	If Yes, please explain: _____		

10.	Have you, as the owner, the pharmacy, or any employee been excluded or debarred from participation in any Federal healthcare programs by either the Office of Inspector General (OIG) or the General Services Administration (GSA), or any other applicable Federal law or regulation?	☐	☐
		Yes	No
	If Yes, please explain: _____		

11.	Is the Pharmacy willing to disclose any disciplinary action or investigation taken against the Pharmacy?	☐	☐
		Yes	No
	If No, please explain: _____		

Pharmacy Insurance Coverage:

Please also include a copy of coverage with the application.

Carrier: _____

Policy #: _____ Agent: _____

Agent Phone #: _____ Agent Fax #: _____

Amount per Claim (min requirement of \$1 million): _____

Amount per Occurrence (min requirement of \$3 million): _____

Are the store pharmacists covered under this policy?

☐
Yes☐
No**Section D: Pharmacy Employees**

Please list ALL pharmacy employees. Attach additional sheets if needed.

Pharmacist In Charge:

Name: _____

License #: _____ State Issued: _____ Exp Date: _____

Pharmacist(s):

Name: _____

License #: _____ State Issued: _____ Exp Date: _____

Name: _____

License #: _____ State Issued: _____ Exp Date: _____

Pharmacy Technicians:

Name: _____

License #: _____ State Issued: _____ Exp Date: _____

Name: _____

License #: _____ State Issued: _____ Exp Date: _____

1.	Does the pharmacy regularly monitor and provide oversight of the operations of the pharmacy and pharmacists including licensing and credentialing programs?	☐	☐
		Yes	No
2.	Does the pharmacy maintain a credentialing program for itself and each of its pharmacists and pharmacy technicians?	☐	☐
		Yes	No

Section E: Pharmacy Policies and Procedures

1.	Does the pharmacy dispense the majority of commercially available retail prescription drugs, and is not limited to specific types or categories?	☐	☐
		Yes	No
	If No, please list the categories the pharmacy is able to dispense:		

2.	Does the pharmacy provide services to all patients, and not just to patients with specific clinical conditions?	☐	☐
		Yes	No
	If No, please list the specific clinical conditions: _____		

3.	Is the pharmacy able to transmit claims electronically in NCPDP format?	☐	☐
		Yes	No
4.	Is the pharmacy able to participate in an online Drug Utilization Review?	☐	☐
		Yes	No
5.	Is your pharmacy able to participate in external audits and grievance procedures?	☐	☐
		Yes	No
6.	Does the pharmacy currently provide and agree to continue to provide the necessary training to its staff to comply with all State and Federal laws, regulations and programs?	☐	☐
		Yes	No
7.	Does the pharmacy comply with the regulations to protect Protected Health Information (PHI) under applicable Federal & State laws and regulations?	☐	☐
		Yes	No
	What is the pharmacy's current policy for destruction of PHI? _____		

8.	Will the pharmacy maintain patient profiles, prescriptions and signature logs as required by applicable State, Federal, and US Territorial laws, and advise members that their signature acknowledges their receipt of prescriptions and allow release of any and all claim information?	☐ Yes	☐ No
9.	Does the pharmacy have written policies to actively review operations and finances to minimize fraud waste and abuse?	☐ Yes	☐ No
	If Yes, please explain: _____ _____ _____		
10.	Is the pharmacy willing to comply with SelectHealth therapeutic, generic sampling and formulary programs?	☐ Yes	☐ No
11.	Does the pharmacy acknowledge that waiving member copays is against the pharmacy contract and/or pharmacy provider manual?	☐ Yes	☐ No
12.	Has the pharmacy staff completed Cultural Competency Training?	☐ Yes	☐ No

Section F: Prescriber Affiliations and Marketing Materials			
1.	Does the pharmacy offer direct or indirect compensation to physicians or other prescribers for referrals to prescribe specific compounded drugs or to direct prescriptions to particular pharmacies?	☐ Yes	☐ No
2.	Does the pharmacy market or promote drug services at trade shows, to payers, physicians or other prescribers?	☐ Yes	☐ No
3.	Does the pharmacy have any partnerships with prescribing physicians?	☐ Yes	☐ No
4.	Does the pharmacy market physicians or other prescribers to promote the pharmacy's services, or any specific compound preparation or prescription?	☐ Yes	☐ No

Section G: Compounding

Does the pharmacy process compounded drug claims?

☐

Yes

☐

No

If Yes, complete the following:

1. Does the pharmacy have: ☐ Clean Room ☐ Oven ☐ Hood

2. Is the pharmacy a member of: ☐ PCCA ☐ Medisca ☐ Freedom

3. Is the pharmacy a:

☐ Sterile, Low and Medium Compounding

☐ Sterile, High Compounding

☐ Non-Sterile Basic Compounding

☐ Non-Sterile Complex Compounding

4. Is the pharmacy accredited by the Pharmacy Compounding Accreditation Board (PCAB)?

☐

Yes

☐

No

If Yes, accreditation date: _____ Exp date: _____

5. Is the pharmacy a §503A Pharmacy?

☐

Yes

☐

No

6. Is the pharmacy a §503B Pharmacy?

☐

Yes

☐

No

7. Are all bulk, raw, chemical ingredients used by the pharmacy in compounded drugs purchased from FDA-registered manufacturing facilities?

☐

Yes

☐

No

If No, please explain: _____

8. Are all bulk, raw, chemical ingredients used by the pharmacy in compounded drugs approved by the FDA?

☐

Yes

☐

No

If No, please explain: _____

9. Does the pharmacy engage in anticipatory compounding?

☐

Yes

☐

No

10. Is the pharmacy accredited, certified and/or licensed for sterile compounding?

☐

Yes

☐

No

If Yes, what organization: _____

11. Has the pharmacy location and compounded drugs been independently tested/inspected for sterility?

☐

Yes

☐

No

If yes, please provide a copy of the report.

12. Does the pharmacy have an area for aseptic compounding of sterile preparations that meets current USP <797> standards?

☐

Yes

☐

No

13. Are all sterile compounds prepared in a barrier isolator which has been certified as ISO 5 by an independent contractor?

☐

Yes

☐

No

If Yes, please identify the contractor: _____

Section H: 340(B) Certification

Pharmacy hereby certifies that as of the Date of this Application hereof that Pharmacy:

☐

IS a provider for and is eligible to distribute Drug Products under the Public Health Service Act, Section 340(B)

OR

☐

IS NOT a provider for and is not eligible to distribute Drug Products under the Public Health Service Act, Section 340(B)

If the pharmacy is a 340(B) Covered Entity, does the pharmacy segregate inventory?

☐

Yes

☐

No

If yes, please indicate the percentage of prescriptions purchased and dispensed under the 340(B) program. _____

Section J: Attestation

I attest that the undersigned entity reviews the OIG and GSA exclusion lists on the start date for every new employee, and annually thereafter, to ensure that no 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: _____