MEDTRAKRx

INDEPENDENT PHARMACY CREDENTIALING APPLICATION

Please take the following steps to apply for access to the MedTrakRx Pharmacy Network

Step One: Complete the application below. Please ensure all applicable fields are populated as incomplete submissions will not be accepted.

Step Two: Return your submitted application. Submissions can be returned via:

Fax: 913-322-8498

Email: TradeRelations@MedTrakRx.com

Mail: MedTrakRx
Attn: Trade Relations
10895 Lowell Ave. Suite 100
Overland Park, KS 66210

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

- ☐ Copy of Certificate of Liability (minimum $1 million occurrence/$3 million annual aggregate)
- ☐ Pharmacy License (Puerto Rico Only)

Additional Documentation Requested:

- ☐ State Pharmacy License
- ☐ Pharmacist-in-Charge State License
- ☐ Federal Tax ID Certificate
- ☐ Unrestricted Full DEA Certificate2-5
- ☐ Sterile Compounding Certification (if applicable)

This is only an application for participation and does not guarantee access into the Network.

MEDTRAKRx

INDEPENDENT PHARMACY CREDENTIALING APPLICATION

General Provider Information

NCPDP #:_____ NPI #:_____ Chain Code#:_____

Provider Legal Name:_____ Store #: _____

Provider DBA Name:_____

Physical Address:_____ Building/Suite#:_____

City:_____ County:_____ State:_____ Zip:_____

Have you had a change of ownership in the last 18 months? **Yes** ☐ **No** ☐

Date Opened/Acquired:_____

Did the new owner obtain a new NPI and NABP? **Yes** ☐ **No** ☐ **N/A** ☐

If yes, include copy of NCPDP notice which reflects effective date of new NCPDP

NABP#:_____ NPI#:_____

Has your pharmacy recently joined, switched or left your current PSAO? **Yes** ☐ **No** ☐

If yes, who is your current PSAO? _____

Contact Information

Mailing Address:_____ Building/Suite#:_____

City:_____ State:_____ Zip:_____

Telephone #:_____ Fax #:_____

Owner's Legal Name:_____ Email:_____

Primary Contact:_____ Email:_____

After-Hours Phone Number:_____

Note: By providing a fax number and/or email address, you are giving permission to MedTrakRx to contact you via fax and/or email.

Pharmacy Operations

Does your pharmacy provide emergency or after hours Rx services? **Yes** ☐ **No** ☐

If yes, please provide emergency phone number:_____

Does your pharmacy offer delivery service? **Yes** ☐ **No** ☐

Does your pharmacy ship or mail prescriptions? **Yes** ☐ **No** ☐ If yes, what percent?_____

Hours of Operation

24-Hour Pharmacy: **Yes** ☐ **No** ☐

If no, list your Hours of Operation:

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

Location description

Select one

☐ Free Standing ☐ Strip Mall ☐ Grocery Store
☐ Hospital ☐ Clinic ☐ Medical Office

Provider Class

Select one

☐ Independent ☐ Hospital/Clinic ☐ PSAO
☐ Chain ☐ Franchise ☐ Government/Federal

Provider Type

Select one

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

Services

Check all that apply

☐ Compounding ☐ Open 24 Hours ☐ Assisted Living
☐ E-Prescriptions ☐ Flu Shots/ Vaccines ☐ Diabetes
☐ Drug Dependency ☐ TTY (Text Telephone) ☐ Specialty Drugs
☐ Translation Services ☐ Delivery ☐ 340B
☐ Hospice ☐ Nuclear Meds ☐ Other:

Languages Spoken

Check all that apply

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

Ownership Information

List any individuals with an ownership or controlling interest in Provider, including, but not limited to, officers, directors, and managing employees.

First and Last Name	Home Address	Date of Birth (MM/DD/YYYY)	Ownership Percentage

Pharmacy Staff

PHARMACY MANAGER:

Name:_____ Date of Birth (DOB): _____

Licensed Professional: **Yes** ☐ **No** ☐ If yes, what Profession: _____

License #:_____ State Issued: _____

PHARMACIST(S):

Name:_____ Date of Birth (DOB): _____

State License #:_____ State Issued:_____Expires On: _____

Name:_____ Date of Birth (DOB): _____

State License #:_____ State Issued:_____Expires On: _____

Name:_____ Date of Birth (DOB): _____

State License #:_____ State Issued:_____Expires On: _____

Member Access

Please answer questions 1-3. If you answer "No" to any question, please explain. Please attach additional pages if necessary.

1. Is this facility open-door, where prescriptions are filled for all walk-in customers without restrictions? **Yes** ☐ **No** ☐
2. Is this facility able to transmit claims electronically in accordance with standards established by the National Council for Pharmacy Drug Program (NCPDP)? **Yes** ☐ **No** ☐
3. Will the Pharmacy disclose any disciplinary actions or investigations taken against the Pharmacy?

   Yes ☐ **No** ☐

Please answer questions 4-23. If you answer "Yes" to any question, please explain. Please attach additional pages if necessary.

4. Does the owner of your facility currently own any other pharmacies within the MedTrakRx or EnvisionRx pharmacy network? (Or has the owner previously owned?) **Yes** ☐ **No** ☐

   If "Yes", list pharmacy Name(s) and NCPDP number(s) below:

   Pharmacy Name:_____ NCPDP #:_____

   Pharmacy Name:_____NCPDP #:_____
5. Other than the name listed, has another business or trade name ever been or is currently being used by Participating Pharmacy (ies)? **Yes** ☐ **No** ☐

   If yes, what was the Participating Pharmacy's previous NCPDP#?_____
6. Are there any owners of the pharmacy that are licensed physicians/prescribers? **Yes** ☐ **No** ☐
7. Has Participating Pharmacy(ies) ever been denied a permit or pharmacy license in any state, or had its permit or license revoked or suspended? **Yes** ☐ **No** ☐
8. Has the Participating Pharmacy(ies), or any of its present owners, employees or officers, ever been charged with a criminal offense involving government business or has the Participating Pharmacy(ies), or any of its present owners, employees or officers, ever been convicted of federal or state drug or pharmacy service-related law convictions? **Yes** ☐ **No** ☐
9. Has Participating Pharmacy(ies) been named in any professional liability judgements or settlements in the past 5 years? **Yes** ☐ **No** ☐

10. Does the pharmacy have any offshore activity that involves the use of PHI (i.e. call center, claims reconciliation, etc.)? **Yes** ☐ **No** ☐

11. Has the pharmacy's(ies') malpractice coverage been denied or cancelled within the past 5 years?

    Yes ☐ **No** ☐

12. 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** ☐

13. Under the current ownership, has this facility or any other previously owned facility ever been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority within the past five (5) years?

    Yes ☐ **No** ☐

14. Have any of the owners, managers, pharmacists or pharmacy technicians been disciplined by a State Board of Pharmacy, a government entity, or any other regulatory authority within the past five (5) years? **Yes** ☐ **No** ☐

15. Under the current ownership, has this facility or any owner, manager, pharmacists or pharmacy technician been the subject of a civil lawsuit or criminal prosecution for fraud, deceit, deception, or a similar offense involving moral corruption? **Yes** ☐ **No** ☐

16. Has the Participating Pharmacy(ies) ever been the subject to any outstanding 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** ☐

17. Has Participating Pharmacy(ies) had one or more public agreements or transactions (Federal, state, or local) terminated for cause or default? **Yes** ☐ **No** ☐

18. Is Participating Pharmacy(ies) under any restrictions of practice as imposed by the State Board of Pharmacy? **Yes** ☐ **No** ☐

19. What is the most recent date that Participating Pharmacy(ies) was inspected by the State Board of Pharmacy? (mm/dd/yyyy) _____

20. Has Participating Pharmacy(ies) ever been terminated by a third party payor, prescription benefit management organization, managed care organization or other similar organization(s)?

    Yes ☐ **No** ☐

21. Has Participating Pharmacy(ies) been excluded from participation for a 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** ☐

22. Has Participating Pharmacy(ies) ever been listed by a governmental agency as debarred from work with that agency, proposed for debarment from a governmental agency, or suspended from any government work, or otherwise precluded from participating in any Federal program?

    Yes ☐ **No** ☐

23. Has the DEA registration of the Pharmacy ever been suspended or revoked? **Yes** ☐ **No** ☐

Mail Order (ONLY COMPLETE IF APPLICABLE)

1. Does this facility utilizemail-order? **Yes** ☐ **No** ☐

   Please list all the states in which your pharmacy is licensed to provide **mail order** prescription services:

STATE	LICENSE#	EXPIRATION DATE

2. Is your pharmacy licensed in each state that it will mail covered prescription services, including compliance with any non-resident pharmacy requirements? **Yes** ☐ **No** ☐

   Please list each state(s) that pharmacy mails or intends to mail prescription drug products.

   _____

   _____

   _____

   _____

Include a separate document with all additional active state licensures if number exceeds the space above.

Required Signature

The undersigned hereby authorizes MedTrakRx 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 MedTrakRx 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 material to MedTrakRx in connection with its credentialing process. Potential Participating Pharmacies have the right to review the information obtained from any outside primary source and the right to correct erroneous information submitted by another party. By signing, Participating Pharmacy(ies) agree(s) that all locations are bound by the terms and conditions of this Agreement.

Provider Name (Please print):_____ NCPDP:_____

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

Signature:_____ Date:_____

Operational Assessment

1. Is the pharmacy able to participate in external audits and grievance procedures? **Yes** ☐ **No** ☐

   If no, please explain on a separate sheet of paper.

2. Switch Link: (*Check one)*

   ☐ Relay Health ☐ Emdeon ☐ eRx ☐ Freedom ☐ DataRx ☐ QS1 ☐ Other:

3. Is this facility able to transmit claims electronically in accordance with standards established by the National Council for Pharmacy Drug Program (NCPDP)? **Yes** ☐ **No** ☐

   If no, please explain on a separate sheet of paper.

4. Can your pharmacy software receive the following NCPDP messages? *(Check all that apply)*

   ☐ Duplicate Therapy ☐ Drug Interactions ☐ All messages returned in the additional message field 526- FQ

5. Will the pharmacy maintain patient profiles, prescription, 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 claim information? **Yes** ☐ **No** ☐

6. Does your pharmacy have a policy to destroy and/or return expired medications on the shelf? **Yes** ☐ **No** ☐

7. Does your pharmacy routinely dispense written drug information with its prescriptions? **Yes** ☐ **No** ☐

   If yes, attach a sample of your drug information to this application.

Compounding (ONLY COMPLETE IF APPLICABLE)

1. Does your pharmacy compound medication? **Yes** ☐ **No** ☐

   If yes, what percent of your business is devoted to compounding? _____

   When was your Compounding Pharmacy last inspected? _____

2. Does your pharmacy perform Sterile Compounding? **Yes** ☐ **No** ☐

3. Is pharmacy accredited, certified and/or licensed for sterile compounding? **Yes** ☐ **No** ☐

   If yes, by what organization?_____

4. Does pharmacy compound only patient-specific prescriptions written by a prescriber (not batch of non-patient specific medications)? **Yes** ☐ **No** ☐

5. Does the pharmacy engage in anticipatory compounding? **Yes** ☐ **No** ☐

6. Does your pharmacy have areas set aside for patient consultation? **Yes** ☐ **No** ☐

7. If you have more than one Participating Pharmacy Location, would you like to be set up for central payment? **Yes** ☐ **No** ☐

8. Payment Information Format: *(Select one)* ☐ **Paper Remittance** ☐ **Electronic ANSI 835**

9. Does your pharmacy perform vaccinations/immunization administration? (i.e. flu shots)? **Yes** ☐ **No** ☐

10. Is the pharmacy easily accessible and open to the general public? **Yes** ☐ **No** ☐

11. Do you coordinate with Medicare Part B? **Yes** ☐ **No** ☐

12. Is the pharmacy able to comply with OBRA 90 rules and regulations? **Yes** ☐ **No** ☐

Contact Information

Contracting Contact: (Third Party Contracting/primary contact)

Name:_____

Address:_____

City:_____ST:_____Zip code:_____

Phone:_____Fax:_____Email:_____

Credentialing Contact: (Request for updating all pharmacy credentialing information)

Name:_____

Address:_____

City:_____ST:_____Zip code:_____

Phone:_____Fax:_____Email:_____

Operations Contact: (For chain pharmacy adds/deletes/updates)

Name:_____

Address:_____

City:_____ST:_____Zip code:_____

Phone:_____Fax:_____Email:_____

Audit Contact: (For discussing audits and audit issues)

Name:_____

Address:_____

City:_____ST:_____Zip code:_____

Phone:_____Fax:_____Email:_____

Electronic Remittance Contact:

Name:_____

Address:_____

City:_____ST:_____Zip code:_____

Phone:_____Fax:_____Email:_____

Help Desk Contact: (Chain or PSAO support line for pharmacies)

Phone:_____Email:_____

Certification and Signature

All information provided above, in connection with the credentialing of this facility is complete and accurate to the best of my knowledge 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 understand and agree that a photocopy of this authorization will be as valid as the original.

Signature:_____ Date:_____

Printed Name:_____ Title:_____