TPA Services Third-Party Administrator
PHARMACY NETWORK ENROLLMENT FORM

INSTRUCTIONS

Network Enrollment Help Desk: TPA Services 939-293-2232/customerservice@tpasvcs.com

The Applicant must provide all requested and required information listed in the Checklist to this form; and, any additional applicable documentation must be attached to the submission of this Pharmacy Network Enrollment Form. If you need additional space to answer, please attach additional pages.

If any questions or fields in this Pharmacy Credentialing Form are left blank or if any of the required documents are not provided, the Pharmacy Credentialing Form and your request for participation may be rejected. Please ensure that you submit ALL required information and documentation. Before completing this enrollment form, we suggest you contact us at the email below to discuss program requirements.

Please send this Pharmacy credentialing form and copies of all requested documents to TPA Services network credentialing via secure email: customerservice@tpasvcs.com

TPA Services at its own discretion reserves the right to accept or not accept the applicant to its Pharmacy Network.

CHECKLIST

1. This application form
2. A copy of current home state pharmacy license and all nonresident pharmacy licenses
3. Primary source copies of all verifications for all states in which pharmacy holds licenses or registrations
4. A copy of current DEA registration
5. A copy of current pharmacy liability insurance ($10MM/$30MM)
6. A copy of the most recent site visit/inspection record by the board of pharmacy. Must be within the past 12-months.
7. Written explanations required in response to “Pharmacy Background and Discipline” and other application sections, as applicable
8. A copy of current pharmacist license for Pharmacist in Charge (PIC) and copies of licenses for all other licensed staff.
9. Current financial records
10. DNB number
11. List of all officers and owners and the percentage of ownership of each officer and/or owner
12. List of other companies owned by the officers and/or owners

[See Next Pages for Required Additional Application Information]

PHARMACY INFORMATION

Pharmacy Legal Name:

Pharmacy D/B/A, if applicable:

NCPDP#: NPI#: FEIN:

Pharmacy Open Date:

Pharmacy conducts business as:

☐ Corporation ☐ LLC ☐ Partnership ☐ S-Corp ☐ Other: _____

State of organization or incorporation: _____

Pharmacy Physical Address:

City: State: ZIP:

Phone #: E-mail: Fax #:

After Hours Phone #: Emergency Rx Services Phone #: Website Address:

PHARMACY OWNERSHIP INFORMATION

Please list all owner information with at least a 5% stake in pharmacy ownership. Attach additional pages if necessary.

Pharmacy Owner's Legal Name: Pharmacy Owner's SSN #:

Address: City: State: ZIP:

Phone #: E-mail: Fax #:

List all pharmacies owned in whole or in part by Pharmacy's owner currently or at any time in the past five (5) years? ***(Attach additional pages if more space is needed).***

Pharmacy Name Pharmacy Address NCPDP Number

PHARMACY HOURS OF OPERATION

Mon: Tue: Wed: Thu: Fri: Sat: Sun:

Holiday hours:

DELIVERY SERVICES

Prescription Delivery Services?: Yes ☐ No ☐ Delivery Radius:_____ Delivery Fees: _____

If pharmacy offers delivery, does your contract with your PSAO, PBM or other third-party payors allow your pharmacy to deliver? If no, please explain the restrictions:

PHARMACY CREDENTIALING INFORMATION

Pharmacy DEA Registration #: DEA Expiration Date:
Please attach current certificate.

Schedules (check those listed on certificate): ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 4 ☐ 5

Home State License No.: Expiration Date: Last State Inspection Date:
(VPP Inspection Permissible, either must be within the past 12-months)

List all states in which the Pharmacy is licensed along with the following information, and attach copy of license verifications: ***(Attach additional pages if more room is needed)***

State	License Type	License No.	License Expiration Date

PHARMACY INSURANCE INFORMATION

Liability Insurance Carrier Name:

Liability Insurance Policy #:
Please attach ACORD document

Liability Insurance Expiration Date:

Amount Per Occurrence: $

Aggregate: $

PHARMACY STAFF INFORMATION

Pharmacist in Charge (PIC):

PIC Registration #:

PIC Registration Expiration Date:

PHARMACY BACKGROUND AND DISCIPLINE

If you mark "Yes" in response to any of the following questions, you must attach a written statement, referencing the question number and explaining your answer.	**YES**	**NO**
1. Has Pharmacy, its owners, officers, or managers , or any pharmacy owned by Pharmacy's owner, ever had any permit, license, registration, or authority to practice of any kind suspended or revoked by any governmental authority, including but not limited to CMS or any State Board of Pharmacy?	☐	☐
2. Has Pharmacy, its owners, officers, managers, or any pharmacy owned by Pharmacy's owner, ever been disciplined, sanctioned, censored, or had any permit, license, registration, or authority to practice limited or restricted by any governmental authority, including but not limited to CMS or any State Board of Pharmacy?	☐	☐
3. Has Pharmacy, its owners, officers, managers, or any pharmacy owned by Pharmacy's owner, ever had an application or request for any permit, license, registration, or authority to practice rejected or denied by any governmental authority, including but not limited to CMS or any State Board of Pharmacy?	☐	☐
4. Has Pharmacy, its owners, officers, managers, or any pharmacy owned by Pharmacy's owner, been excluded from participation, or listed as debarred or suspended, from any governmental agency or health care program, including but not limited to Medicare, Medicaid, or other federal or state health care programs?	☐	☐
5. Has the permit, license, registration, or authority to practice of any pharmacist employed by Pharmacy been suspended, revoked, disciplined, sanctioned, or censored in any way by any governmental authority, including but not limited to CMS or any State Board of Pharmacy?	☐	☐
6. Has the any pharmacist employed by Pharmacy ever had an application or request for any permit, license, registration, or authority to practice rejected or denied by any governmental authority, including but not limited to CMS or any State Board of Pharmacy?	☐	☐
7. Has any pharmacist employed by Pharmacy ever been excluded from participation, or listed as debarred or suspended, from any governmental agency or program, including but not limited to Medicare, Medicaid, or other federal or state health care programs?	☐	☐
8. Has Pharmacy, its owners, officers, managers, or pharmacists been named in any malpractice lawsuit or had any professional liability claims, judgments, or settlements in the past 5 years?	☐	☐
9. Has Pharmacy, its owners, officers, managers, or pharmacists ever been the subject of a civil lawsuit or criminal prosecution involving fraud or deception, any government health programs, pharmacy laws, controlled substances?	☐	☐
10. Has Pharmacy ever filed bankruptcy, receivership, or reorganization?	☐	☐
11. Has Pharmacy's malpractice coverage been denied or cancelled?	☐	☐

12. Has Pharmacy ever been terminated for cause from participation in a network or from providing pharmacy services by a third-party payor, prescription benefit management organization, managed care organization or other similar organization(s)? ☐ ☐

13. Has Pharmacy been terminated by any PBM, PSAO, or third-party payor network? ☐ ☐

CERTIFICATION

By signing this certification below, I attest that I am a duly authorized agent of Pharmacy for purposes of submitting this Pharmacy Application Form, and that all information submitted in this Form, as well as any attachment or supplemental information, is true, current, and complete as of the date of signature below.

Signature:	**Date:**
Print Name:	**Title:**