

Network Participation Application

If you're interested in becoming part of the PharmPix Pharmacy Network, please send this completed form to our Retail Network Contracting department at retailnetwork@pharmpix.com or by fax to 1 (866) 912-2810. A member of our Retail Network Contracting department will contact you to process your request.		Date:
GENERAL INFORMATION		
PHARMACY NETWORK:		
NCPDP # OR CHAIN CODE:	NPI #:	
LEGAL NAME:		
D/B/A NAME (Corporation):		
PHYSICAL ADDRESS:		
CITY:	STATE:	ZIP:
POSTAL ADDRESS: (If different from above)		
CITY:	STATE:	ZIP:
PHONE:	FAX:	
FEDERAL TAX ID:	STATE TAX ID:	STATE ISSUED FROM:
STORE FEDERAL DEA #: (Attach copy of License)	STORE LICENSE #: (Attach copy of License)	
MEDICAID #:	STATE ISSUED FROM:	
STATE CONTROLLED SUBSTANCE #: (If applicable) Attach copy of License	PHARMACIST IN CHARGE: (Attach copy of Credentials)	
INSURANCE CARRIER**: (Attach Certificate of Insurance)	SOFTWARE VENDOR:	
SWITCHING COMPANY:	CONTACT PERSON: E-MAIL (If available)	
HOURS/DAYS OF SERVICE:	PHARMACY WEBSITE:	
Monday to Friday	_____ AM - _____ PM	<i>* Provider must complete the Provider Certification for <u>each</u> pharmacy location.</i> <i>** We require comprehensive general liability coverage of \$1,000,000 per occurrence / \$3,000,000 annual aggregate. A copy of your liability coverage showing these levels must be attached.</i>
Saturday	_____ AM - _____ PM	
Sunday	_____ AM - _____ PM	
CONTACT PERSON NAME:	CONTACT PERSON SIGNATURE:	DATE: