# RAMSELL PHARMACY SOLUTIONS
# PHARMACY CREDENTIALING VERIFICATION FORM

**Provider Services: 1-888-311-7632 Fax: 1-800-848-4241**

## PHARMACY INFORMATION

Pharmacy NCPDP No: _____ National Provider ID (NPI): _____

Pharmacy Name: _____

Contact Person: _____ Email: _____
*Contact Person's email required*

Pharmacy Address: _____ County: _____

City: _____ State: _____ Zip Code: _____

Phone #: ( ) _____-_____ Fax #: ( ) _____-_____ Pharmacy Email: _____

Does your pharmacy have Internet access? ___Yes ___No E-prescribing capability? _____ Yes _____ No

Pharmacy Permit #: _____ Pharmacy Permit Exp Date: _____ /_____ /_____

Pharmacy DEA #: _____ Pharmacy DEA Exp Date: _____ /_____ /_____

Medicaid Provider Number: _____ Tax ID #: _____
*(Medicaid Provider ID may be required in designated programs)*

Pharmacy Software System: _____ Languages Spoken:_____

Primary Wholesaler: _____ Switch _____ Nonresident Pharmacy Permit # _____

Closed Door Mail Order Pharmacy? _____ Yes _____ No Specialty Pharmacy? _____ Yes _____ No

## PHARMACY SERVICES PROVIDED

Free Rx Delivery ☐ Delivery - Fee Required ☐ Free Mail Order ☐ Mail Order – Fee Required ☐

HIV Specialty _____ % of Rx Activity Home Infusion _____% of Rx Activity Mediset Fills (y/n): _____

Automatic Refill (y/n)_____ Refill Notification (y/n) _____ Compounding Specialty _____% of Activity

Other: _____

**Note: Pharmacy Providers servicing AIDS Drug Assistance Program (ADAP) clients are prohibited from mailing client ADAP prescriptions out of state.**

## PHARMACY HOURS OF OPERATION

Mon – Fri: _____ Sat: _____ Sun: _____ Holidays: _____

*Open 24 hours (y/n): _____ Emergency Rx Services Provided (y/n): _____ Total Hours per week: ☐

## PHARMACY LIABILITY INSURANCE POLICY INFORMATION

*(PROVIDE A COPY OF INSURANCE INFORMATION)*

Liability Insurance Carrier: _____ Policy Number: _____ Exp Date: _____

Amount per Occurrence: _____ Aggregate: _____

Worker's Compensation Insurance Carrier: _____ Policy Number: _____

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## PHARMACY STAFF LICENSE INFORMATION

Name of Pharmacist-In-Charge: _____ License #: _____ Exp. Date: _____

All registered pharmacists are in good standing with the State Board of Pharmacy. Please sign in acknowledgement of this requirement.

Name: _____ Title: _____

Signature: _____ Date: _____

## PUBLIC HEALTH SERVICE PRICING (340B)

**Note: Questions 1 and 4 must be answered.**

### Pharmacy of a Covered Entity

1. Are you eligible to purchase discounted drugs under Section 340B of the Public Health Service Act ("PHS Drug Pricing Program") as an eligible covered entity? _____ Yes _____No

1a. Covered Entity Name: _____ Phone Number: (_____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

2. Do you now purchase medication under the PHS Drug Pricing Program? _____ Yes _____ No
*(If you answered 'Yes' to this question, you must answer the question below.)*

3. Do you dispense medication purchased under the PHS Drug Pricing Program to ADAP (AIDS Drug Assistance Program) clients? _____Yes _____No

### 340B Contracted Pharmacy of a Covered Entity

4. Are you a community pharmacy dispensing medications purchased through the PHS Drug Pricing Program under contract with a 340B covered entity or public health program? _____ Yes _____ No

4a. If you checked "yes" in response to the preceding question, complete the following:

Covered Entity Name: _____ Phone Number: (____) _____-_____

Address: _____ City: _____ State: _____ Zip: _____

5. Do you dispense medication purchased by the covered entity under the PHS Drug Pricing Program to ADAP (AIDS Drug Assistance Program) clients? _____ Yes _____ No

**By signing this pharmacy credentialing verification form, I hereby certify that the information provided is accurate and complete.**

Signed: _____ Date: _____

Title: _____ Phone #: _____