ENVISIONRx

PROVIDER CREDENTIALING AND VERIFICATION TO THE PARTICIPATING PHARMACY AGREEMENT

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

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

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

Fax: 330-405-8094
Email: providerenrollment@envisionrx.com

Mail: Envision Rx
Attn: Network Credentialing
2181 E Aurora Rd
Twinsburg, Ohio 44087

**A coversheet is provided on the final page of this packet for your use.*

Pharmacies located in Puerto Rico must submit enrollment applications to Breyes@envisionrx.com for review prior to submitting to providerenrollment@envisionrx.com.

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

- ☐ Envision Rx Provider Contract Application and Credential Verification
- ☐ Copy of Certificate of Liability **(minimum $1million occurrence/$3 million annual aggregate)**
- ☐ Medicare ID award Notice or Medicare ID Number
- ☐ Department De Salud Certificado De Registro (Puerto Rico Only)
- ☐ Pharmacy License (Puerto Rico Only)

Additional Documentation Requested:

- ☐ State Pharmacy License
- ☐ Pharmacist-in-Charge State License
- ☐ Unrestricted Full DEA Certificate 2-5
- ☐ Photo of Pharmacy dispensing area
- ☐ Photo of store front (including signage)
- ☐ Medicaid Provider Notice (*for all states Medicaid authorized*)
- ☐ Sterile Compounding Certification (if applicable)
- ☐ Board of Equalization Permit (CA Only)
- ☐ Federal Tax ID Certificate
- ☐ W9

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

Please allow 10-15 business days for the processing of your submitted application. If approved, a Participating Provider Agreement packet will be emailed to you at the address designated on your application. Please allow at least 30 days before you are able to process prescription claims. If denied, you will be notified via email and will have an opportunity to appeal. Appeals should be submitted to credentialingappeals@envisionrx.com. To check the status of your application ***after 15 business days,*** email your request to providerenrollment@envisionrx.com; include in the subject line your NCPDP number and "Contract Application Status".

Network Access request (select all that apply):

Commercial:_____Medicare:_____Preferred Network:_____Medicaid:_____Dispensing Physician: _____

General Provider Information – Required

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 Acquired:_____

If yes, is there a Power of Attorney (POA) in place? Yes_____No_____
(If yes, include a copy of POA with enrollment application)

Did the new owner obtain a new NPI and NABP? Yes_____No_____

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

Contact Information

Mailing Address:_____Building/Suite #:_____

City:_____State:_____Zip:_____

Telephone #:_____Fax #:_____

Owner's Legal Name:_____Email:_____

Primary Contact:_____Email:_____

After Hours Phone Number:_____

** By providing a fax number and/or email address, you are giving permission to Rx Options, Inc., to contact you via fax and/or email.*

Identification Numbers

Is your pharmacy a supplier of DME (Durable Medical Equipment)? Yes_____ No_____

If your answer to the question above is Yes, please provide your Medicare PTAN# below.

If your answer to the question above is No, please write Not Applicable.

Medicare PTAN #:_____ Federal Tax ID:_____

Medicaid ID #:_____ State:_____

Is your pharmacy contracted for Medicaid? Yes_____ No_____ If yes, which states:_____

Please include supporting documentation affirming all states contracted to participate in Medicaid

Facility Liability Insurance Information

Insurance Carrier:_____ Policy #:_____

Policy Effective Date:_____ Policy Expiration Date:_____

Each Occurrence Limit:_____ General Aggregate Limit:_____

(Minimum requirement is $1M) (Minimum requirement is $3M)

Attach a current copy of your Certificate of Liability Insurance to this application. Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network.

Facility State License Information

Rx Options, Inc. will verify all state licenses using primary source verification and may review license history including all disciplinary actions. ** Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network. **

Facility State License Number:_____

Issue Date:_____ Expiration Date:_____

Additional States Licensed:_____

Attach a current copy of your Facility State License to this application. Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network.

Facility DEA Certificate Information

Rx Options, Inc. will verify the facility's DEA certificate using primary source verification. Rx. Options, Inc. does not allow providers into the Network without an active DEA certificate.

DEA Registration Number:_____

Issue Date:_____Expiration Date:_____

Schedules (check those listed on certificate) 2____2N_____3_____3N_____4_____5_____

Attach a current copy of your Facility DEA Certificate to this application. Any application received without a Certificate of Liability Insurance will not be reviewed or considered for participation in the Network.

Pharmacy Operations

Does your pharmacy provide emergency Rx services?
Yes_____No_____
If yes please provide emergency phone number:_____

Hours of Operations

If no, list your Hours of Operation:

24 Hour Pharmacy: Yes__No____

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

Location description

(check option that applies)

Free Standing		Grocery Store		Strip Mall	
Clinic		Hospital		Medial Office	

Provider Class

(Select one)

Independent		PSAO	
Chain		Franchise	
Hospital/Clinic		Government/ Federal	

Provider Type

(Select one)

Retail		Clinic Pharmacy	
Mail Order		Home Infusion	
Long Term Care		VA Hospital	
Dispensing Physician		Indian Health	
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		French	
Spanish		Chinese		Arabic		Creole	
Japanese		Farsi		Armenian		Other:	

Member Access

Please answer questions 1-6. 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. Is the Pharmacist-In-Charge (or Pharmacy Manager) a licensed pharmacist employed by this facility?
   Yes_____No_____

4. Does this facility provide secure access to staff-only areas? Yes_____No_____

5. Is this facility compliant with applicable access standards related to the Americans with Disabilities Act of 1990 (or its successor) and able to accommodate individuals with physical and non-physical disabilities, including but not limited to: wheelchair accessibility, ample handicap parking, clear display of signage and way finding, availability of public transportation to the facility and, where applicable, waiting room furnishings?
   Yes_____No_____

6. Will the Pharmacy disclose any disciplinary actions or investigations taken against the Pharmacy?
   Yes_____No_____

Please answer questions 7-26. If you answer "Yes" " to any question, please explain. Please attach additional pages if necessary.

7. Does your facility use pharmacists employed through an agency or are your pharmacists responsibilities outsourced to another company/agency? Yes_____No_____

   If "Yes", list the name of the company/agency_____

8. Does the owner of your facility currently own or has previously owned any other pharmacies within the EnvisionRx pharmacy network? Yes_____No_____

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

   Pharmacy Name:_____ NCPDP #:_____

   Pharmacy Name:_____NCPDP #:_____

9. 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#?_____

10. Are there any owners of the pharmacy that are licensed physicians/ prescribers?
    Yes_____No_____

11. 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_____
    If yes, please explain on a separate sheet of paper.

12. 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(s) 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_____
    If yes, please explain on a separate sheet of paper.

13. Has Participating Pharmacy(ies) been named in any professional liability judgements or settlements in the past 5 years? Yes_____No_____If yes, please explain on a separate sheet of paper.

14. Does the pharmacy have any offshore activity that involves the use of PHI (i.e. call center claims reconciliation, etc) Yes_____No_____

15. Has the pharmacy(ies) malpractice coverage been denied or cancelled within the past 5 years?
    Yes_____No_____If yes, please explain on a separate sheet of paper.

16. 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_____
    If yes, please explain on a separate sheet of paper.

17. 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_____

18. 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_____

19. 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_____

20. 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_____
    If yes, please explain on a separate sheet of paper.

21. Has Participating Pharmacy(ies) had one or more public agreements or transactions (Federal, state, or local) terminated for cause or default? Yes_____No_____
    If yes, please explain on a separate sheet of paper.

22. Is Participating Pharmacy(ies) under any restrictions of practice as imposed by the State Board of Pharmacy? Yes_____No_____If yes, please explain on a separate sheet of paper.

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

24. 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_____If yes, please explain on a separate sheet of paper.

25. 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_____
    If yes, please explain on a separate sheet of paper.

26. 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_____If yes, please explain on a separate sheet of paper

27. Has the DEA registration of the Pharmacy ever been suspended or revoked?
Yes_____No_____If yes, please explain on a separate sheet of paper.

Immunization Services (ONLY COMPLETE IF APPLICABLE)

Primary Certified Immunization Pharmacist (CIP):_____

Additional CIP(s):_____

Immunization certification effective/ expiration:_____

Accreditation Authority:_____

Immunization Attestation: *Initial each Attestation item to affirm compliance with requirements*

All administering PICs attest to the meeting of all State Board of Pharmacy requirements	
My state board allows for pharmacists to administer immunization without formal training or certification	
I accept assignment to administer immunizations to Medicare Patients	
I am certified to administer immunizations to children	
My pharmacy administers immunizations to adults, 18 and older, only	
I can provide copies of all applicable PIC certifications upon request	
I can provide copies of all applicable pharmacy certifications upon request	

***Please note that pharmacies in Puerto Rico requesting to administer vaccines must be in compliance with the Commonwealth of Puerto Rico, all pharmacies must comply with the Department of Health regulations as defined in (*Article 9.06 Vaccine)* regarding on-site immunizations including certification requirements for the pharmacist as an immunizer. Please include your Department of Health Certificate with the application along with the Immunizer Pharmacist credentials.**

Mail Order (ONLY COMPLETE IF APPLICABLE)

1. Does this facility utilize mail order? Yes_____No_____

Please list all of 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]

**Classification definitions per NCPDP*

Required Signature

The undersigned hereby authorizes EnvisionRx 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 EnvisionRx 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 EnvisionRx 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 this Exhibit C, Participating Pharmacy(ies) agrees 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. Are you a 340B provider? (As defined by 42 U.S.C §256b (a)(4))
   Yes_____No_____
   (ATTACHED COPY OF THE 340(b) PHARMACEUTICAL PURCHASING WAIVER, IF APPLICABLE)

   340 ID Number:_____

   Entity Type: _____

   Start date: _____

2. Is the pharmacy able to participate in external audits and grievance procedures?
Yes_____No_____If No, please explain on a separate sheet of paper.

3. Switch Link Check One:
Relay Health_____Emdeon____eRx____Freedom_____DataRx____QS1____Other_____

4. 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

5. 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_____

6. Does your pharmacy offer delivery service? Yes_____No_____

7. Does your pharmacy ship or mail prescriptions? Yes_____No_____If yes what %_____

8. Does your pharmacy provide durable medical equipment? Yes_____No_____
If yes, is it: Full line:_____or Limited:_____DMEPOS certification number:_____

9. 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_____

10. Does your pharmacy provide special packaging of prescriptions that are required for skilled and/or assisted living facilities? Yes_____No_____

11. Does your pharmacy have a policy to destroy and/or return expired medications on the shelf?
Yes_____No_____

12. 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.*

13. Are you willing to comply with EnvisionRx therapeutic, generic sampling and formulary programs? Yes_____No_____

Compounding (ONLY COMPLETE IF APPLICABLE)

14. Does your pharmacy compound medication? Yes_____No_____

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

    When was your Compounding Pharmacy inspected? _____

    Is the pharmacy equipped with facilities, tools, and stocks of drugs sufficient to permit prompt compounding and dispensing of medications? Yes_____No_____

15. Does your pharmacy perform Sterile Compounding? Yes_____No_____

16. Is pharmacy accredited, certified and/or licensed for sterile compounding? Yes_____No_____

    If yes, by what organization?_____

17. Does your pharmacy have a: Clean Room_____Oven_____Hood_____

18. Is your pharmacy a: Sterile, Low and Medium Compounding_____

    Sterile, High Compounding_____Non-Sterile Complex Compounding_____

    Non-Sterile Basic Compounding_____

19. Does the pharmacy have policy and procedure reflecting that USP 795(Non sterile compounding) USP 797 (Sterile Compounding) guidelines are in place? Yes_____No_____

    If yes indicate all that apply: USP 795_____USP 797_____

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

21. Have pharmacy location facilities and Compounded Drugs been independently tested/ inspected for sterility? Yes_____No_____If yes, please provide copy of the inspection/ testing report.

22. 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 independent contractor:_____

23. Are all bulk, raw chemical ingredients used by pharmacy in Compound Drugs purchased from FDA-registered manufacturing facilities? Yes_____No_____

24. Are all bulk, raw, chemical ingredients used by the pharmacy in Compounded Drugs approved by the FDA? Yes_____No_____If no, please explain_____

25. Does pharmacy compound only patient-specific prescriptions written by a prescriber (not batch of non-patient specific medications) Yes_____No_____

26. Does the pharmacy engage in anticipatory compounding? Yes_____No_____

27. Does your pharmacy have areas set aside for patient consultation? Yes_____No_____

28. If you have more than one Participating Pharmacy Location, would you like to be set up for central payment? Yes_____No_____

29. Payment Information Format: (Select One)
Paper Remittance_____Electronic ANSI 835_____

30. Does your pharmacy perform vaccinations/immunization administration? (i.e. flu shots)? Yes_____No_____

31. Is the pharmacy easily accessible and open to the general public? Yes_____No_____

32. Do you coordinate with Medicare Part B? Yes_____No_____

33. Is the pharmacy able to comply with OBRA 90 rules and regulations? Yes_____No_____

Long Term Care (LTC) Service & Requirements (ONLY COMPLETE IF APPLICABLE)

Check here if not applicable_____Percentage of business for LTC_____

Please list all of the states in which your pharmacy is licensed to provide Long Term Care prescription services

STATE	LICENSE#	EXPIRATION DATE

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

*Classification definitions per NCPDP

1. Comprehensive Inventory and Inventory Capacity Yes_____No_____

2. Special Packaging Yes_____No_____

3. IV Medications Yes_____No_____

4. Compounding/Alternative Drug Composition Yes_____No_____

5. Pharmacist On-Call Service Yes_____No_____

6. Delivery Service Yes_____No_____

7. Emergency Boxes Yes_____No_____

8. Emergency Log Books and Services Yes_____No_____

9. Does your Pharmacy or group of Pharmacies collect cost sharing for LIS eligible beneficiaries? Yes_____No_____

10. Distribution or Consulting Yes_____No_____

Home Infusion Pharmacy: (ONLY COMPLETE IF APPLICABLE)

Home Infusion State Licensure

Not applicable_____

Percentage of business for HI_____

Per CMS [42 CFR §423.120(a)(4)], a Home Infusion pharmacy must meet the minimum requirements as defined below:

(i) Are capable of delivering home-infused drugs in a form that can be administered in a Clinically appropriate fashion.

(ii) Are capable of providing infusible Part D drugs for both short-term acute care and long-term chronic care therapies.

(iii) Ensure that the professional services and ancillary supplies necessary for home infusion therapy are in place before dispensing Part D home infusion drugs.

(iv) Provide delivery of home infusion drugs within 24 hours of discharge from an acute care setting, or later if so prescribed.

My Pharmacy location meets the minimum requirements listed above from CMS and is indeed a Home Infusion pharmacy

Please list all of the states in which your pharmacy is licensed to provide Home Infusion prescription services to Medicare Part D beneficiaries:

State:_____

License # _____

Exp. Date: _____

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

ENVISIONRx CONTACT INFORMATION

Pharmacy Help Desks

Please see member card for information regarding the number to call for questions or issues. When member card is not available: call EnvisionRx Customer Service at 1-800-361-4542. The EnvisionRx Customer Service call center can be reached 24 hours a day, seven days a week.

The pharmacy help desk is available to assist you with the following: Claims processing issues, billing and payment inquiries, formulary questions, prior authorizations, plan and group information, and general inquiries

EnvisionRx Website

EnvisionRx makes every effort to keep pharmacies informed and up-to-date on the latest operational information, procedures and requirements for EnvisionRx on our website located at: www.envisionrx.com.

Compliance Hotline reports go directly to our Compliance Department vendor voicemail box for assessment and investigation of the reported issue. Some examples of reportable fraud include forgery, suspicious claims, pharmacy and/or doctor shopping, identity theft, kickbacks and drug diversion. If you suspect a possible compliance concern please contact the EnvisionRx Compliance Hotline

Telephone: 1-866-417-3069 Or
Report Online:
myethicsline.envisionrx.com

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:_____

**Pharmacies not utilizing contact information provided to NCPDP are responsible for updating EnvisionRxOptions by submitting written request to Pharmcyaudits@envisionrx.com or via fax at 844-236-3021. Excludes routine desk audits and investigational audits performed by Benefit Integrity Department.

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. I understand this application does not guarantee participation in the Network. I understand Rx Options, Inc. will use a variety of sources, including primary sources, to verify the contents of this application and will inspect all documents from individuals and organizations having information pertaining to the operation of this facility. If any discrepancies are found with the information provided in this application, I understand that this facility and any other facilities under the same ownership, may be denied, terminated or suspended from access to the Network and may be subject to an audit as outlined in 42 C.F.R. § 423.504. 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 agree that Rx Options, Inc., its' representatives, employees and agents shall not be liable for any act or omission related to the evaluation or verification of the information provided. I further agree to notify Rx Options, Inc. within 10 (ten) business days, of any change in the information provided.

I understand and agree that a photocopy of this authorization will be as valid as the original.

Signature:_____ Date:_____

Printed Name:_____ Title:_____

Network Application EnvisionRx Fax / Mail / Email

To: EnvisionRx
Attn: Credentialing Department
Date:_____

(Please Print Clearly)
Pharmacy Name:_____

Pharmacy Contact:_____

NCPDP:_____NPI:_____

Phone:_____Email:_____

# of Pages:_____of_____

Pharmacies located in Puerto Rico must submit enrollment applications to Breyes@envisionrx.com for review prior to submitting to providerenrollment@envisionrx.com.

Required application documents included:

- ☐ Envision Rx Provider Contract Application and Credential Verification
- ☐ Copy of Certificate of Liability **(minimum $1million occurrence/$3 million annual aggregate)**
- ☐ Medicare ID award Notice or Medicare ID Number
- ☐ Department De Salud Certificado De Registro (Puerto Rico Only)
- ☐ Pharmacy License (Puerto Rico Only)

Additional Documentation Requested:

- ☐ State Pharmacy License
- ☐ Pharmacist-in-Charge State License
- ☐ Unrestricted Full DEA Certificate 2-5
- ☐ Photo of Pharmacy dispensing area
- ☐ Photo of store front (including signage)
- ☐ Medicaid Provider Notice (*for all states Medicaid authorized*)
- ☐ Sterile Compounding Certification (if applicable)
- ☐ Board of Equalization Permit (CA Only)
- ☐ Federal Tax ID Certificate
- ☐ W9

Comments:_____

_____

_____

_____