# REQUEST OF INFORMATION DUE TO CHANGE

**Credentialing Requirements**

**Copies of:**

1. Pharmacy License
2. ASSMCA License
3. DEA License
4. Biological Product License
5, Insurance Liability, including Druggist Liability
6. Evidence of NPI
7. Evidence of NCPDP (NABP)
8. Disclosure Statement for Medicaid and Medicare Program (42 C.F.R. Sec 455.100-104-106)
9. Chief Pharmacist "Regente"
   - Registration with photo
   - License
   - Pharmacist Membership "Colegiación"
10. Pharmacy Technician Registration (if applicable)

1. Direct phone and fax line.
2. Evidence of training to Prevent Fraud, Waste and Abuse / HIPAA.
3. Reasonable availability and variety of products including, but not limited to, generic products and brand products approved by the FDA as well as OTC.
4. Pharmacy minimum service hours of six (6) days a week, ten (10) hours a day, except Sundays.

**PHARMACY PROFILE**

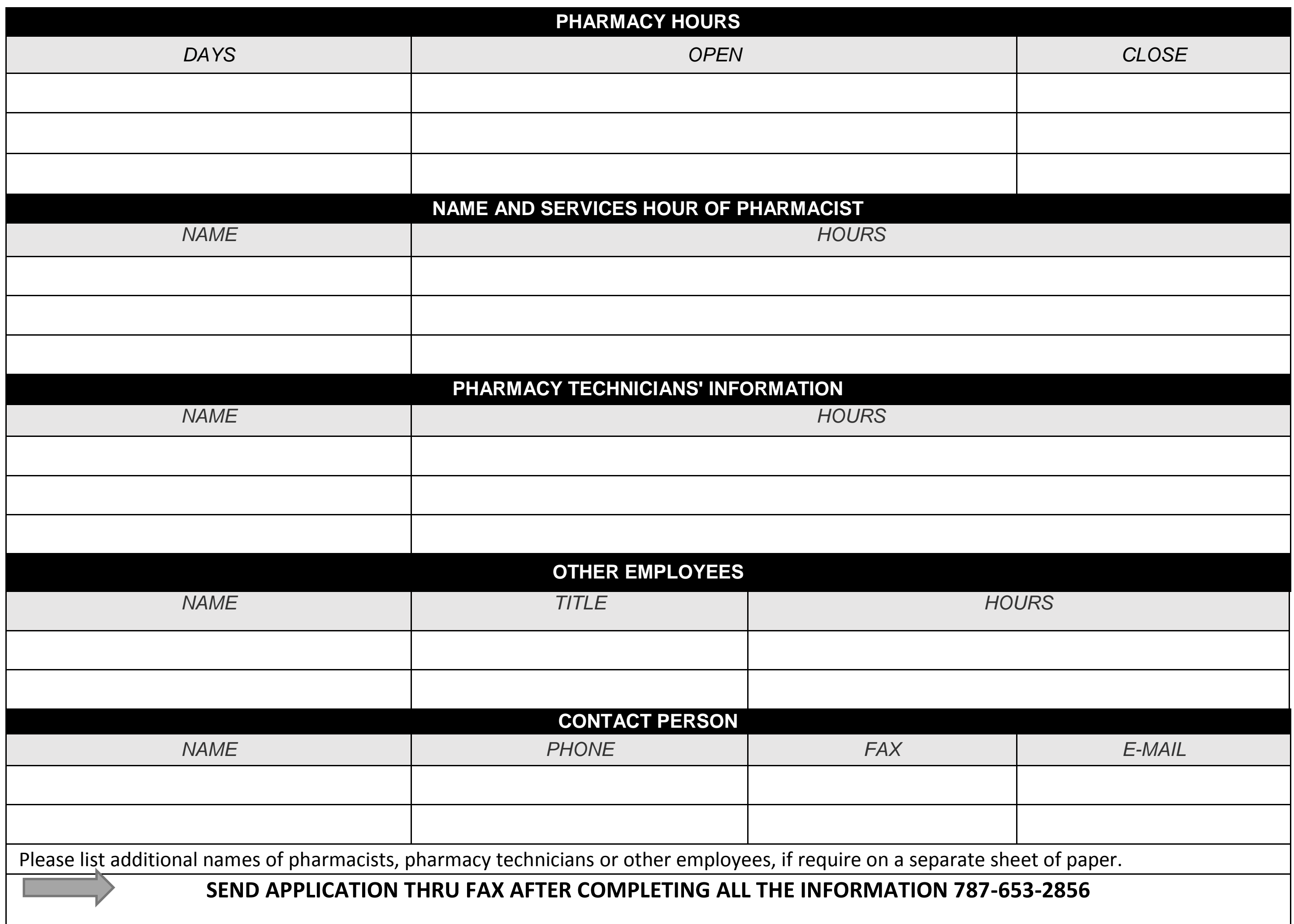
**TYPE OF PHARMACY: (  )** Independent **(  )** Hospital / CDT **(  )** Chain **(  )** Specialty | **Date:**

| | | |
|---|---|---|
| Old Pharmacy Name:<br>New Pharmacy Name: | Store Number: | Pharmacy Processing Software: (ex. Rx30, QS/1) |
| Pharmacy Manager: (if applicable) | Old Chief Pharmacist Name:<br>New Chief Pharmacist Name: | |
| Old Pharmacy Owner Name:<br>New Pharmacy Owner Name: | Old Pharmacy Owner SSN:<br>New Pharmacy Owner SSN | Physical Facilities: **(  )** Waiting Area<br>**(  )** PHI Management Procedure |
| Pharmacy affiliations: | Is your pharmacy Incorporated? **(  )** Yes **(  )** No<br>(if yes, please provide copy of the Incorporation Certificate) | |
| Mailing Address: | Physical Address: | |
| Pharmacy E-Mail: | Pharmacy Phone Number(s): | Pharmacy Fax Number(s): |
| Employer ID Number: | Old NCPDP Number:<br>New NCPDP Number: | Old NPI Number:<br>New NPI Number |

**APPLICATION FORM MUST HAVE THE FOLLOWING DOCUMENTS**

| CREDENTIALS | Y | N | VALID DATE | EXPIRATION DATE | LICENSE OR POLICY # |
|---|---|---|---|---|---|
| Pharmacy State License | | | | | |
| ASSMCA License | | | | | |
| DEA License | | | | | |
| Liability Insurance, including Druggist Liability | | | | | |
| Biological Product License | | | | | |
| Chief Pharmacy License | | | | | |
| Regent Pharmacist Registration with Photo | | | | | |
| Regent Pharmacist Collegiate Member Certificate | | | | | |
| Pharmacy Technician Registration (if applicable) | | | | | |

| If pharmacy is Incorporated, include copy of the Incorporation Certificate of the State Department | | | | | |
|---|---|---|---|---|---|
| JCHA Certificate for Specialty Pharmacies (if applicable) | | | | | |
| NPI Evidence | | | | | |
| NCPDP/NABP Evidence | | | | | |
| Compliance, FWA and HIPAA Training Attestation Evidence | | | | | |
| Standards of Conduct Distribution/Attestation | | | | | |
| OIG Pharmacy | | | | | |
| OIG Regent Pharmacist Verify | | | | | |
| Letter notifying why changes are been made. | | | | | |
| Copy of an Id of person requesting the changes | | | | | |
| Change of owner must include sales contract. | | | | | |



| PHARMACY HOURS | | |
|---|---|---|
| *DAYS* | *OPEN* | *CLOSE* |
| | | |
| | | |
| | | |

| NAME AND SERVICES HOUR OF PHARMACIST | |
|---|---|
| *NAME* | *HOURS* |
| | |
| | |
| | |

| PHARMACY TECHNICIANS' INFORMATION | |
|---|---|
| *NAME* | *HOURS* |
| | |
| | |
| | |

| OTHER EMPLOYEES | | |
|---|---|---|
| *NAME* | *TITLE* | *HOURS* |
| | | |
| | | |

| CONTACT PERSON | | | |
|---|---|---|---|
| *NAME* | *PHONE* | *FAX* | *E-MAIL* |
| | | | |
| | | | |

Please list additional names of pharmacists, pharmacy technicians or other employees, if require on a separate sheet of paper.

**SEND APPLICATION THRU FAX AFTER COMPLETING ALL THE INFORMATION 787-653-2856**

## GENERAL QUESTIONS

( ) Yes ( ) No 1. Is your pharmacy currently participating in a franchise?
If yes, name of franchise: ___________________________________________

( ) Yes ( ) No 2. Has your pharmacy or Pharmacist-in-charge (PIC) ever been denied a license or permit or had its license or permit suspended, revoked, or been fined or had other disciplinary action by the State Board of Pharmacy or other federal or state licensing or regulatory authorities? If yes, provide a letter of explanation and include the dates.

( ) Yes ( ) No 3. Has the pharmacy or any of its present owners, officers, or employees ever been convicted of any state or federal law convictions?

The undersigned hereby authorizes MC-21 Corporation and its designated agents to review any and all records that it reasonably believes necessary for credentialing purposes.

**Signature of Authorized Pharmacy Representative.**

I certify, represent and warrant that any and all information provided to each of the items related to this credentialing application and in connection with the 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 MC-21 Corporation ("MC-21") in connection with its credentialing process. Failure to provide true, accurate, and complete information in this credentialing application may result in sanctions, up to and including denial to participate and/or termination from all MC-21 Pharmacy Networks.

Signature: _________________________________________ Date: __________________________________

Print Name: ________________________________________

## ⬇INFORMATION TO BE COMPLETED ONLY BY MC-21⬇

Reviewed by: _________________________________ Date: ____________________________________

Approved by: _________________________________ Date: ____________________________________

( ) Pharmacy comply with all Credentialing Application requirements.

Comments: ______________________________________________________________________________________

**DISCLOSURE STATEMENT**

Pursuant Federal Law (42 C.F.R. Sec. 455.100-104-106), Providers are required to submit a full and accurate disclosure of ownership and financial interest. Completion and submission of this statement is a condition of participation in the Medicare or Medicaid program and is also/will be a contractual obligation with MC-21 Corporation (MC-21). **Failure to submit the requested information may result in a refusal by MC-21 Corporation ("MC-21") to enter into contract with any such Provider or in termination of existing contracts.**

If this form is being completed by an Individual Provider, the signature at the end of the form must be the written signature of the Provider. Otherwise, the signature at the end of the form must be the written signature of an Authorized Representative of the Participating Pharmacy who must be a partner, president or secretary of the Disclosing Entity.

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**Item I. Identifying Information**

| (a) Do you practice as: ☐ an individual pharmacy provider ☐ a disclosing entity |
|---|
| (b) Name of Individual, Facility or Organization: |
| (c) DBA Name: |
| (d) Address: |
| (e) Federal Income Tax Identification Number (TIN) or Social Security Number: |
| (f) Is this entity chain affiliated? ☐ Yes ☐ No |

**Item II. Ownership and Control Interest Information for Disclosing Entity 42 C.F.R. §§ 455.100-104**

**a)** List the name, title, address, and SSN for each **office and/or individual** who has any ownership or controlling interest in this Disclosing Entity. The office/individual's ownership or controlling interest is an ownership interest of 5% or more of this Disclosing Entity. List the name, Tax ID (TIN), and address of any **organization, corporation, or entity** having any ownership or controlling interest in this Disclosing Entity. The ownership or controlling interest is an ownership interest of 5% or more in this Disclosing Entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN/TIN | % owned |
|---|---|---|---|---|
| | | | | |
| | | | | |

**b)** List those persons named in Item II (a) that are related to each other (spouse, parent, child or sibling). 42 C.F.R. § 455.104. Use an additional sheet if necessary.

| Name | Relationship | SSN |
|---|---|---|
| | | |
| | | |

**c)** List the following information for each person with an Ownership or Control Interest in any Subcontractor that this disclosing entity has a direct or indirect ownership of 5% or more of. 42 C.F.R. § 455.104. Use an additional sheet if necessary.

| Name | Title | Personal and/or Business Address | SSN/TIN | % owned |
|---|---|---|---|---|
| | | | | |
| | | | | |

**d)** List the following information for any other disclosing entity in which a person with an Ownership or Controlling Interest in this disclosing entity, has an Ownership or Control Interest of at least 5% or more. 42 C.F.R. § 455.104. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN/TIN | % owned |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Item III. Business Transaction Information. 42 C.F.R. §455.105.**

**a)** List the ownership of any subcontractor with whom this Provider has had business transactions totaling more than $25,000 during the previous 12-month period. 42 C.F.R. §455.105. Use an additional sheet if necessary.

| Name | Title | Personal and/or Business Address | Contracted Date |
|---|---|---|---|
| | | | |
| | | | |

**b)** List any significant business transactions between this Provider and any wholly owned supplier, or between this Provider and any Subcontractor, during the previous 5-year period. 42 C.F.R. §455.105.

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| |

**Item IV. Managing Employee**

Provide detailed information regarding the identity of any person who is an agent or managing employee of the Provider. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN |
|---|---|---|---|
| | | | |
| | | | |

**Item V. Criminal Offenses and Exclusions 42 C.F.R. §§ 455.100, 106**

**A.** If you are filling out this form as an individual provider giving information about yourself, please answer the following questions:

**1)** Have you personally been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services programs since the inception of those programs?
☐ No ☐ Yes

**2)** Has someone connected to your practice (i.e. an office manager or director) been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs?
☐ No ☐ Yes

If you answered yes above, please provide the following information for each person convicted of a criminal offense. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN/TIN |
|---|---|---|---|
| | | | |
| | | | |

**3)** If you answered Item II (a) on Page 3 as an individual AND your practice is incorporated, please list the name and addresses of the corporations Officers and Board of Directors in the spaces below. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN/TIN |
|---|---|---|---|
| | | | |
| | | | |

**B.** If you are filling this form out as an Authorized Representative of a Disclosing Entity, providing information about the business entity, please answer the following question:

Have you or any Director, Officer, Agent, managing employee, or other individual or organization having ownership or control interest in this provider been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid or Title XX services program since the inception of those programs?
☐ No ☐ Yes

If you answered yes above, please provide the following information for each individual or entity.

| Name | Title | Personal and/or Business Address | SSN/TIN |
|---|---|---|---|
| | | | |
| | | | |

**Item VI. Status Changes – For Disclosing Entities Only**

a) Has there been a change in ownership or control interest within the last year or is a change of ownership or control anticipated within the year?
☐ No ☐ Yes

b) Is this facility operated by a management company or leased in whole or partly by another organization?
☐ No ☐ Yes

If Yes, list date of change in operations:

c) 1. Is this facility chain affiliated? If yes list the name, address and EIN# of parent corporation
☐ No ☐ Yes

| Name | Business Address | EIN # |
|---|---|---|
| | | |

2. If you answered "No" on question c, (1.) above, was this facility ever affiliated with a chain? If yes list the name, address and EIN # of parent organization
☐ No ☐ Yes

| Name | Business Address | EIN # |
|---|---|---|
| | | |

**Item VII. Board of Directors or Board of Governors**

List the name, title, personal address, social security number, and percentage of interest for each of the Board of Directors or Board of Governors of this provider. Use an additional sheet if necessary.

| Name | Title | Personal Address | SSN | % owned |
|---|---|---|---|---|
| | | | | |
| | | | | |

**MC-21 Corporation ("MC-21") may refuse to enter into, renew, or terminate an agreement with Provider if it is determined that this entity did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106**

**I certify, represent and warrant that any and all information provided to each of the items related to this Disclosure Statement and in connection with the 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 MC-21 in connection with its credentialing process. Failure to provide true, accurate, and complete information in this credentialing application may results in sanctions, up to and including denial to participate and/or termination from all MC-21 Pharmacy Networks.**

______________________________________

**PRINT NAME OF PROVIDER**

**Signed By:** ______________________________ **Date:** ______________________________

**Name:** ______________________________ **NCPDP:** ______________________________

**Title:** ______________________________ **NPI:** ______________________________