



REQUEST OF INFORMATION DUE TO CHANGE

Credentialing Requirements

Copies of:

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

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:	Store Number:	Pharmacy Processing Software: (ex. Rx30, QS/1)
New Pharmacy Name:		
Pharmacy Manager: (if applicable)		Old Chief Pharmacist Name:
		New Chief Pharmacist Name:
Old Pharmacy Owner Name:	Old Pharmacy Owner SSN:	Physical Facilities: () Waiting Area () PHI Management
New Pharmacy Owner Name:	New Pharmacy Owner SSN	Procedure
Pharmacy affiliations:	Is your pharmacy Incorporated? () Yes () No (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:	Old NPI Number:
	New NCPDP Number:	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

<i>DAYS</i>	<i>OPEN</i>	<i>CLOSE</i>

NAME AND SERVICES HOUR OF PHARMACIST

<i>NAME</i>	<i>HOURS</i>

PHARMACY TECHNICIANS' INFORMATION

<i>NAME</i>	<i>HOURS</i>

OTHER EMPLOYEES

<i>NAME</i>	<i>TITLE</i>	<i>HOURS</i>

CONTACT PERSON

<i>NAME</i>	<i>PHONE</i>	<i>FAX</i>	<i>E-MAIL</i>

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



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

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 LLC 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 LLC ("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: _____

Title: _____

 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 LLC (MC-21). Failure to submit the requested information may result in a refusal by MC-21 LLC ("**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.

Item I. Identifying Information

(a) Do you practice as: <input type="checkbox"/> an individual pharmacy provider <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

<p>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? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>		
<p>b) Is this facility operated by a management company or leased in whole or partly by another organization? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, list date of change in operations:</p>		
<p>c) 1. Is this facility chain affiliated? If yes list the name, address and EIN# of parent corporation <input type="checkbox"/> No <input type="checkbox"/> Yes</p>		
Name	Business Address	EIN #
<p>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 <input type="checkbox"/> No <input type="checkbox"/> Yes</p>		
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 LLC ("**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 result 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: _____