Independent Health | 511 Farber Lakes Drive Buffalo, NY 14221

Pharmacy Benefit Dimensions® An Independent Health company

INDEPENDENT HEALTH ASSOCIATION INC PARTICIPATING CHAIN CREDENTIALING APPLICATION

Chain Name: _____ **Chain Code:** _____

Corporate Address: _____

Contact Phone and Email: _____

Please ensure you have included the following: (Excel Spreadsheet is recommended for pharmacy information)

Pharmacy Insurance Certificate	DEA License #	Supervising Pharmacist Name
Pharmacy Insurance Expiration Date	DEA Expiration	Supervising Pharmacist License Expiration
NABP	State License #	Supervising Pharmacist License #
Pharmacy Name(s) & Address(es)	State License Expiration	W-9 Form

PROFESSIONAL QUESTIONS

Please circle yes or no:

1. Has any facility license to practice been denied, restricted, limited, suspended, or revoked; if so, was the revocation or suspension stayed? *Yes or No*
2. Has any facility been reprimanded by any state licensing or office of professional discipline? *Yes or No*
3. Has any facility DEA registration been restricted, limited, suspended, revoked, or are any of these actions pending with respect to your DEA registration? *Yes or No*
4. Has the DEA registration been voluntarily relinquished? *Yes or No*
5. Has participation in Medicare, Medicaid, or other government program or private program been denied, suspended, or revoked in any facility? *Yes or No*
6. Have any professional liability judgements been entered against any facility, including arbitration, or are any suits pending? *Yes or No*
7. Have any professional liability claim settlements been paid by you on the facility's behalf? *Yes or No*
8. Has any facilities' professional liability insurance been canceled, reduced, lapsed, or denied proper liability coverage? *Yes or No*

Please include a separate document providing the circumstances associated with a Yes answer to any of the above questions.

This is to certify that the information contained in this application is complete and accurate and I agree to provide information as required to support this application.

Print Name: _____ **Signature:** _____

Title: _____ **Date:**_____

Please return the signed attestation with attachments to PBD's credentialing department:
Email: PBDCred@pbdrx.com

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Prime Source Verification Attestation for Chain Pharmacy

_____attests that prime source verification (PSV) of store licensure and DEA license has occurred and is current for all locations, and that prime source or secondary source verification of all locations professional liability insurance coverage meets Independent Health's minimum coverage requirements of $1,000,000 occurrence/$1,000,000 aggregate. In addition, pharmacies are reviewed for sanctions or disciplinary action on Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and System of Award Management (SAM).

Print Name: _____ **Signature:** _____

Title: _____ **Date:**_____

Please return the signed attestation with a copy of your PSV policy/procedure to PBD's credentialing department:
Email: PBDCred@pbdrx.com