Independent Health | 511 Farber Lakes Drive Buffalo, NY 14221

Pharmacy Benefit Dimensions® An Independent Health company

INDEPENDENT HEALTH ASSOCIATION INC PARTICIPATING PHARMACY CREDENTIALING APPLICATION

Pharmacy Name: _____ **NCPDP/NABP:** _____

Corporate Address: _____ **Chain Code:** _____

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 & Address	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