Optum Rx®

Provider Network Participation Request Form

The below information will need to be completed before any credentialing requirements/pharmacy network agreements will be sent out. This does NOT guarantee the pharmacy's eligibility to apply to the Optum Rx networks.

Provider Information

Today's Date:	NCPDP/NPI:		
Provider Legal Name:			
Provider DBA Name:			
☐Chain ☐PSAO ☐Independent	Chain Code/s:	Chain/Affiliate Name:	
Pharmacy Type: ☐ Retail ☐ Clinic ☐ Outpatient Hospital ☐ Home Infusion ☐ Long Term Care ☐ IHS ☐ 340B ☐ Rural			
NCPDP Dispenser Types	Primary:	Secondary:	Tertiary:
Services Offered: ☐ Compounding ☐ DME ☐ Mail ☐ Specialty/Limited Distribution ☐ Standard Pharmacy Services			
Pharmacy Address:	City:	State:	Zip Code:
Contact Name:	Email:	Phone:	Fax:

Additional Information

1. If you are affiliated with a PSAO please provide termination date. Date _____
2. Change of Ownership ☐Yes ☐No
   If yes, please provide old NCPDP# _____
3. Store Open / Effective Date _____
4. Is your pharmacy located on a Federal Indian Reservation within the United States? ☐Yes ☐No
5. Does your pharmacy dispense medications to Medicaid beneficiaries? ☐Yes ☐No
   If yes, please provide your pharmacy's Medicaid ID with the associated state/s so we can consider you for inclusion in those programs. below:

State	Medicaid ID

Questionnaire

1. Identify the health plan or state managed Medicaid program that you seek to participate in*: ☐ All ☐ other _____
2. Is your pharmacy utilizing a consultant? ☐ Yes ☐ No
   a. If yes, provide consultant(s) name and contact information: _____
3. Indicate if your pharmacy is a: ☐ "Walk-In Retail Pharmacy" or ☐ "Closed Door/Central Fill Pharmacy"
4. Does the pharmacy currently maintain a retail agreement with Optum Rx? ☐ Yes ☐ No
5. Is the pharmacy licensed in non-resident states? ☐ Yes ☐ No

Please note that specialty network participation requirements are plan specific. If you do not indicate a particular health plan/state managed Medicaid program network you will be enrolled in the broad networks.

Signature Information (individual authorized to execute Agreement)

Name:	Title:	Email:

Please submit the Provider Network Participation Request Form by fax or email below:

- Email: independent.contracting@optum.com
- Fax: 844-305-2623