Provider Network Participation Request Form

Provider Information			
Today's Date:	Provider Legal Name:	☐Chain ☐PSAO ☐Independent	
NCPDP/NPI Number:	Affiliate Code (i.e. Chain or PSAO	Affiliate Name:	
Pharmacy Type: ☐Retail ☐Clinic ☐Outpatient Hospital ☐Mail ☐Home Infusion ☐Long Term Care ☐IHS ☐340B ☐Rural			
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

State	Medicaid ID

Signature Information

Name of individual authorized to execute Agreement:	Title:	Email:

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

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